90-1058

No. _____

Supreme Court, U.S.
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In The

Supreme Court of the United States

October Term, 1990

THE MEDICAL PROTECTIVE COMPANY,

Petitioner,

vs.

FLETCHER BELL,

Respondent.

Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

PETITION FOR A WRIT OF CERTIORARI

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I.
QUESTION PRESENTED FOR REVIEW

The question presented is whether, in a declaratory judgment action involving choice of law issues pending in federal court in Missouri, the right of a party to the benefits intended by the constitutional grant of diversity jurisdiction is violated by the automatic adoption of untenable Kansas case law that fails to consider choice of law issues and operates to protect Kansas' financial interests at the expense of out-of-state parties.

II.

LIST OF PARTIES

The parties to the proceedings below were the petitioner The Medical Protective Company and the respondent Fletcher Bell. Fletcher Bell was originally named as defendant in this action in his capacity as Commissioner of Insurance for the State of Kansas, and administrator of the Kansas Health Care Stabilization Fund (the "Kansas Fund"). Petitioner believes that Fletcher Bell's term as Commissioner of Insurance for the State of Kansas has expired or will soon expire, and that another individual has been elected to replace Fletcher Bell, although no formal substitution motion has been made by respondent. Pursuant to United States Supreme Court Rule 29.1, petitioner The Medical Protective Company states that it is a wholly-owned subsidiary of Medical Protective Corporation.

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In The

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THE MEDICAL PROTECTIVE COMPANY,

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vs.

FLETCHER BELL,

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Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

PETITION FOR A WRIT OF CERTIORARI

Petitioner The Medical Protective Company, by and through counsel, respectfully prays that a writ of certiorari issue to review the judgment and opinion of the United States Court of Appeals for the Eighth Circuit in this case.

OPINIONS BELOW

The opinion of the United States District Court for the Western District of Missouri (Whipple, J.) (App., *infra*, A5-A39) is reported at 716 F. Supp. 392.

The opinion of the Court of Appeals for the Eighth Circuit (App., *infra*, A1-A4) is reported at 912 F.2d 244. The Eighth Circuit's order denying petitioner's petition for rehearing and suggestion for rehearing en banc is reprinted in the Appendix, *infra*, A40.

JURISDICTION

The United States District Court for the Western District of Missouri entered judgment in favor of petitioner The Medical Protective Company on May 10, 1989. On respondent's appeal, the Eighth Circuit Court of Appeals on March 12, 1990, reversed the District Court's judgment. Thereafter, petitioner The Medical Protective Company filed a petition for rehearing by the panel, or in the alternative for rehearing en banc. The petition for rehearing was denied by the Eighth Circuit on October 3, 1990.

The jurisdiction of this Court to review the judgment of the Eighth Circuit Court of Appeals is invoked under 28 U.S.C. § 1254(1).

CONSTITUTIONAL AND STATUTORY PROVISIONS INVOLVED

1. Article III Section 2 of the United States Constitution provides in relevant part that "[t]he judicial Power shall extend to . . . controversies . . . between Citizens of different States. . . . "

2. Pursuant to 28 U.S.C. § 1332(a), "[t]he district courts shall have original jurisdiction of all civil actions

where the matter in controversy exceeds the sum or value of $50,000, exclusive of interests and costs, and is between – (1) citizens of different states. . . . "

STATEMENT OF THE CASE

1. Factual Background

The basis for federal jurisdiction below was pursuant to federal diversity jurisdiction as provided for by 28 U.S.C. § 1332(a). This case involves the settlement of a medical malpractice claim against two physicians and their corporate employer by the expenditure of funds exceeding the primary policy limits of medical malpractice insurance issued to the two physicians. The issue before the District Court was whether the excess carrier for the physicians, as opposed to the insurance carrier for the vicariously liable employer, should be responsible to pay the excess amount. The Medical Protective Company brought this action seeking a declaratory judgment to resolve this issue, requesting a finding that the Kansas Fund, as excess carrier for the physicians under the Kansas Health Care Provider Insurance Availability Act, must indemnify The Medical Protective Company, carrier for the vicariously liable employer, for $515,000, the amount expended by The Medical Protective Company in excess of its primary coverages of the physicians to settle the medical malpractice claim.

The Kansas Health Care Provider Insurance Availability Act (the "Kansas Act") K.S.A. § 40-3401, *et seq.*, requires every health care provider operating in Kansas, regardless of residence, to maintain a specified minimum

amount of professional liability insurance, and in this case, $100,000 was the minimum amount per occurrence required to be maintained. K.S.A. § 40-3402. The Kansas Act provides the Kansas Fund is liable to pay any "amount due from a judgment or settlement which is in excess of the basic coverage or liability of all liable resident health care providers or resident self-insurers for any such injury or death arising out of the rendering or failure to render professional services within or without [Kansas]." K.S.A. § 40-3403(c)(1). The Kansas Fund is, in effect, an excess insurance carrier. *See Stephens v. Snyder Clinic Assoc.*, 631 P.2d 222, 226 (Kan. 1981).

The two physicians in the instant case, Andrew B. Kaufman, M.D., and Robert A. Morantz, M.D., resided in Kansas and were licensed to practice in Kansas. Both physicians therefore were subject to the mandatory provisions of the Kansas Act, even though both were employed by Arnold Schoolman, M.D., a Missouri corporation, and both practiced medicine in Missouri. Dr. Morantz and Dr. Kaufman maintained professional liability policies with The Medical Protective Company to satisfy the Kansas Act's $100,000 minimum coverage requirement. The Missouri corporation was not subject to the provisions of the Kansas Act, but also maintained a liability policy with The Medical Protective Company.

In 1983, Dr. Kaufman and Dr. Morantz, along with the Missouri corporation, were named as defendants in a medical malpractice action brought in the Circuit Court of Jackson County, Missouri. The action arose out of medical care rendered in Missouri by Dr. Morantz and Dr. Kaufman, and the basis for the action against the Missouri corporation was as employer of Dr. Morantz and

Dr. Kaufman. The Medical Protective Company settled the claim on behalf of the physicians and the corporation for $715,000, and out of this amount $200,000 was provided from the Kaufman and Morantz liability policies. Prior to the settlement, however, The Medical Protective Company demanded that the Kansas Fund assume responsibility for $515,000, the amount in excess of the policy limits to the individual doctors. The Kansas Fund refused to pay this amount on the theory it had no obligation to Dr. Kaufman or Dr. Morantz until the limits of The Medical Protective Company policy issued to the Missouri corporation were exhausted.

2. Proceedings in the Lower Courts

The Medical Protective Company filed this request for declaratory relief against respondent Fletcher Bell, who was sued in his capacity as Commissioner of Insurance for the state of Kansas and administrator of the Kansas Fund. This matter was submitted to District Court Judge Dean Whipple through joint stipulations of fact, supporting legal briefs, and oral argument. Thereafter, the District Court granted the relief requested herein by The Medical Protective Company. In a detailed 37-page slip opinion, filed on May 10, 1989, and subsequently published in the *Federal Supplement*, the District Court held that The Medical Protective Company was entitled to reimbursement from the Kansas Fund, holding that where the settlement of a claim requires expenditure of sums exceeding the primary policy limit of an employee/tort-feasor, the employee's excess carrier, not the carrier for a vicariously liable employer, must pay the excess.

The District Court's opinion was based on its interpretation of the Kansas Act, applicable legal principles regarding statutory and contract construction, and rules defining the relative liability of employers and their insurers. Significantly, the District Court held Missouri law applied to certain issues involving contract questions, legal principles involved in the underlying tort action, and insurance law.

Following oral argument before a panel of the United States Court of Appeals for the Eighth Circuit on March 12, 1990, the panel entered an opinion filed August 21, 1990, reversing the District Court's opinion. In reversing the District Court opinion, the Eighth Circuit did not engage in a lengthy examination of the legal issues in this case, but instead adopted without analysis the decision of the Kansas Supreme Court in *Obstetrics & Gynecology Ltd. v. Buckner,* 795 P.2d 386 (Kan. 1990). The decision of the Kansas Supreme Court in *Buckner* was filed on July 30, 1990, only approximately three weeks prior to the Eighth Circuit's decision herein. Relying solely on the Kansas Supreme Court's decision in *Buckner,* the panel below concluded that the Kansas Act does not require the Kansas Fund to make the contribution sought by The Medical Protective Company.

The Medical Protective Company filed a timely petition for rehearing by the panel and for rehearing en banc, which thereafter was denied by the Eighth Circuit.

REASONS FOR GRANTING THE PETITION

The Medical Protective Company submits that the decision of the Court of Appeals is in conflict with Article

III of the United States Constitution because the panel's automatic adoption of the Kansas Supreme Court decision in *Buckner* deprived The Medical Protective Company, a non-citizen of the state of Kansas, of the independent judgment of the federal judiciary, and thereby subjected The Medical Protective Company to a decision of a state court that operated to protect that state's financial interest and incorrectly resolved the issue in question. In so doing, the Eighth Circuit failed to provide The Medical Protective Company with the benefit of diversity jurisdiction, which was intended by the Constitution to protect non-residents from the effect of real or apparent local prejudice by state courts. The untenability of the Kansas Supreme Court decision in *Buckner* is illustrated by the fact that *Buckner* is fundamentally inconsistent with a prior decision of the Eighth Circuit, *Pacific Nat'l Ins. Co. v. Transport Ins. Co.*, 341 F.2d 514 (8th Cir. 1965), in which the Eighth Circuit stated that in the context of determining insurance coverage in a vicarious liability situation, the insurer of a party subject to vicarious liability is entitled to indemnity from the tort-feasor's insurer.

1. The Eighth Circuit Below Failed to Apply Existing Standards For Federal Court Interpretation of a State Statute

In adopting the Kansas Supreme Court decision in *Buckner*, the Eighth Circuit failed to analyze the wisdom or correctness of that decision, but instead applied *Buckner* in a purely reflexive manner, stating that as "a federal court interpreting a state statute, we are 'bound by that construction given the statute by the highest court within

the state' that promulgated that measure." *The Medical Protective Company v. Bell*, 912 F.2d 244, 245 (8th Cir. 1990). In so doing, the Eighth Circuit failed to consider critical exceptions to that rule, exceptions that are applicable here.

A federal court need not accept the state court's interpretation of its laws if such an interpretation is "inconsistent with fundamental principles of liberty and justice." *Ewing v. Winans*, 749 F.2d 607, 609 (10th Cir. 1984). Moreover, federal courts should not adopt a state court interpretation of state law that is "clearly untenable and amounts to a subterfuge to avoid federal review of a deprivation by the state of rights guaranteed by the Constitution." *Knapp v. Cardwell*, 667 F.2d 1253, 1260 (9th Cir. 1982).

In the instant case, the automatic adoption of *Buckner* by the Eighth Circuit effectively deprived The Medical Protective Company of its right to have this diversity claim resolved by a federal court, a right guaranteed by Article III of the Constitution. Moreover, the decision of the Kansas Supreme Court in *Buckner* is untenable and has serious Constitutional implications because of the extra-territorial effect that results from the mandatory provisions of the Kansas Act.

2. The Kansas Act has a Substantial Effect on Non-Kansas Residents by Virtue of its Mandatory Provisions

The Medical Protective Company is a medical malpractice insurer with its principle place of business in the state of Indiana. It issued a policy of insurance to Arnold

Schoolman, M.D., a Missouri corporation, with its principal place of business in the state of Missouri. The subject of this declaratory judgment action involves the liability of The Medical Protective Company on its policy to the Missouri corporation, as The Medical Protective Company has already paid the limits of its policies issued to Dr. Morantz and Dr. Kaufman, the Kansas resident physicians practicing in Missouri. The issue is whether the Kansas Fund is liable as excess insurer of physicians Morantz and Kaufman.

One of the major features of the Kansas Act is the requirement that all health care providers licensed by Kansas must obtain professional malpractice liability insurance (K.S.A. § 40-3402), and must pay a surcharge to the Kansas Fund (K.S.A. § 40-3404). In return, the Kansas Fund is statutorily obligated to pay for claims in excess of policy limits (K.S.A. § 40-3403). The Kansas Act is not limited in its application to Kansas or nonresident physicians who practice exclusively in Kansas, but also applies its mandatory provisions to Kansas physicians licensed by Kansas who practice partially or exclusively in other states, such as Missouri. Moreover, the coverage provisions of the Kansas Act specifically contemplate coverage for tortious activity arising outside the state of Kansas (K.S.A. § 40-3403).

The extraterritorial effect of the Kansas Act is of critical importance because it calls into question the propriety of unlimited deference to the Kansas Supreme Court as arbitrator of the issue involved in this dispute. The enforcement of the Kansas Act on physicians with respect to their professional activities in states other than Kansas creates a substantial impact beyond the state of

Kansas, through employers such as the Missouri corporation, and through insurers of both employers and employees. The Medical Protective Company, and many other insurers and insureds similarly situated, are nonresidents of Kansas that rely on, are affected by, and are entitled to a fair construction of the Kansas Act. The Kansas Fund is not an entity that is limited to Kansas in its requirements, coverage or effect. As a result, the federal courts should not resolve this dispute by the automatic adoption of the protective stance of the Kansas Supreme Court in interpreting the Kansas statutory scheme.

3. The Eighth Circuit's Adoption of Buckner Deprives The Medical Protective Company of the Benefits of Federal Diversity Jurisdiction

The Kansas Supreme Court's decision in *Buckner* lacks any legal analysis similar to that used by the District Court for the Western District of Missouri in resolving this case. It is significant that a substantial portion of the District Court's decision was devoted to a conflict of law issue, in which the District Court found that Missouri law should apply to certain issues in this case. The decision in *Buckner* involved a significantly different factual scenario than in the instant case, and the decision in *Buckner* is not based on any choice of law issue involving Missouri law.

The Kansas Supreme Court's decision in *Buckner*, which was filed on July 13, 1990, makes no mention whatsoever of the District Court's lengthy decision in this case, which was filed on May 10, 1989, and which had

been published in the *Federal Supplement* for a considerable period of time prior to the decision in *Buckner*. The fact that the Kansas Supreme Court in *Buckner* totally ignored the District Court's decision below should not be overlooked. The Kansas Supreme Court's treatment of this issue follows a pattern in which Kansas appellate courts have protected the Kansas Fund against claims made by insurers or employers who have disputed the Kansas Fund's interpretation of its own statutory scheme. *See Buckner; McGuire v. Sifers*, 681 P.2d 1025 (Kan. 1984); and *Missouri Medical Ins. Co. v. Wong*, 676 P.2d 113 (Kan. 1984). All of these factors support the proposition that the Kansas Supreme Court's decision in *Buckner* is untenable and should not have been adopted by the Eighth Circuit.

The Eighth Circuit's decision adopting *Buckner* effectively defeats the protection of federal diversity jurisdiction. The Constitutional grant of diversity jurisdiction extends to controversies between a state and the citizens of another state, or between citizens of different states. Article III, Section 2, Clause 1, U.S. Constitution. This jurisdiction is implemented by 28 U.S.C. § 1332, and the purpose of diversity jurisdiction is to avoid discrimination against non-residents. *Szantay v. Beech Aircraft, Inc.*, 349 F.2d 60 (4th Cir. 1965). "The traditional explanation for the creation of diversity jurisdiction is, as has been seen, a fear that state courts would be prejudiced against those from out-of-state." C. Wright, *Law of Federal Courts*, p. 133 (4th ed. 1983). "The Constitution authorizes such federal diversity jurisdiction, it is usually thought, in order to protect non-residents of a state from whatever local favoritism distort's the state's court system." L. Tribe, *American Constitutional Law*, p. 157 (2d ed. 1988).

This Court has long considered this to be a compelling reason for diversity jurisdiction:

> However true the fact may be, that the tribunals of the states will administer justice as impartially as those of the nation, to the parties of every description, it is not less true, that the constitution itself either entertains apprehensions on this subject, or views with such indulgence the possible fears and apprehensions of suitors, that it has established national tribunals for the decision of controversies between . . . citizens of different states.

Bank of United States v. Deveaux, 9 U.S. (5 Cranch) 61, 87 (1809).

Similarly, in discussing the rationale for diversity jurisdiction under Article III for cases involving a state and a citizen of another state, this court has noted that the

> [O]bject of vesting in the courts of the United States jurisdiction of suits by one State against the citizens of another was to enable such controversies to be determined by a national tribunal, and thereby to avoid the partiality, or suspicion of partiality, which might exist if the plaintiff State were compelled to resort to the courts of the State of which the defendants were citizens.

Wisconsin v. Pelican Ins. Co., 127 U.S. 289, 8 S. Ct. 1370, 32 L. Ed. 239, 243 (1888).

In addition to defeating the purpose of this Court's diversity jurisdiction, the Eighth Circuit's adoption of *Buckner* implicates a number of other Constitutional guarantees. State legislation that operates to discriminate against non-residents is subject to challenge under the

equal protection clause. *Hooper v. Bernalillo County Assessor*, 472 U.S. 612, 86 L. Ed. 2d 487, 105 S. Ct. 2862 (1985). In addition, state law distinctions based on residency may be violative of the privileges and immunities clause of the Constitution. *Supreme Court of New Hampshire v. Piper*, 470 U.S. 274, 84 L. Ed. 2d 205, 105 S. Ct. 1272 (1985). Moreover, discrimination against out-of-state insurance companies may involve commerce clause implications. *See Metropolitan Life Ins. Co. v. Ward*, 470 U.S. 869, 84 L. Ed. 2d 751, 105 S. Ct. 1676 (1985).

The fact the Kansas Act has a substantial extraterritorial effect on health care providers and insurers by virtue of its mandatory terms requires that a federal court make an independent review of the issues involved in this case. The fact that the decision in *Buckner* is completely lacking in analysis similar to that provided by the District Court indicates there is an unequal application of the Kansas statutory scheme against those who are entitled to its benefits and protection and against those who are non-residents of Kansas. As a result, the Eighth Circuit should not have adopted the untenable position of the Kansas Supreme Court in *Buckner*, but instead should have affirmed the well-reasoned analysis of the District Court below.

4. *Buckner* is Inconsistent with Established Law

The Kansas Supreme Court's opinion in Buckner is inconsistent with a prior decision of the Eighth Circuit resolving a similar issue. In *Pacific Nat'l Ins. Co. v. Transport Ins. Co.*, 341 F.2d 514 (8th Cir. 1965), the Eighth Circuit held that in the context of vicarious liability, an

employer's insurer is entitled to indemnity from an employee's insurer. In *Pacific Nat'l*, a tort action was brought arising out of a trucking accident. The action was brought against an employee and his employer. The employee was insured by Pacific National Insurance Company as a permissive user of a vehicle. The employer was insured by Transport Insurance Company. In the tort action, the underlying plaintiff received a judgment against the employee, and also against the employer on the basis of vicarious liability. Thereafter, the employer's insurance company brought an action seeking indemnity against the employee's insurance company. The premise for the indemnity action was that because the employer was held vicariously liable for the plaintiff's injuries, the employer had the right to proceed by way of indemnity against its employee, and as a result, the employer's insurer therefore was entitled to maintain an action to recover from the employee's insurer.

In affirming the District Court's judgment awarding indemnity to the employer's insurer, the Eighth Circuit in *Pacific Nat'l* stated "recognized authority teaches that as against the person whose personal wrong is responsible for harm to a third-person, one vicariously liable who has been compelled to respond to damages may have complete indemnity." *Id.* at 519. The Eighth Circuit's decision in *Pacific Nat'l* is consistent with established insurance law that requires an employee's insurance to be exhausted before the insurer of a vicariously liable employer is liable. See *Commercial Union v. Chubb Group of Ins. Cos.*, 499 A.2d 1362 (N.J. 1985) (adopting opinion of Brody, J., reported at 476 A.2d 290). In *Chubb*, the court stated that where

> [O]ne liability policy covers his employee for his own negligence and another covers his employer for the same negligence, the employee's policy must first be exhausted before the employer's carrier may be called upon to pay. This reflects the common law rule that a negligent employee must indemnify his employer whose liability is only vicarious.

476 A.2d at 296-297.

It is significant that Kansas case law recognizes the right of indemnity by an employer in a vicarious liability situation. *See Fenly v. Revell*, 228 P.2d 905, 907-908 (Kan. 1951). That fact makes it both ironic and elucidating that the Kansas Supreme Court's decision in *Buckner* failed to recognize such a widely-accepted rule of law. The Eighth Circuit below should not have adopted the untenable decision in *Buckner*, but in so doing deprived The Medical Protective Company of the protection intended by the Constitution's grant of federal diversity jurisdiction.

CONCLUSION

The petition for writ of certiorari should be granted.

Respectfully submitted,

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The MEDICAL PROTECTIVE COMPANY, Appellee,

v.

Fletcher BELL, Appellant.

No. 89-1976WM.

United States Court of Appeals, Eighth Circuit.

Submitted March 12, 1990.

Decided Aug. 21, 1990.

Robert M. Kroenert, Kansas City, Mo., for appellant.

John F. Murphy, Kansas City, Mo., for appellee.

Before FAGG and WOLLMAN, Circuit Judges, and FLOYD R. GIBSON, Senior Circuit Judge.

FAGG, Circuit Judge.

Fletcher Bell, commissioner of insurance for Kansas and administrator of Kansas's Health Care Stabilization Fund (the Fund), appeals from an adverse ruling of the district court. The sole question before us on appeal is whether the Kansas Health Care Provider Insurance Availability Act (the Act) permits the Fund to contribute toward a malpractice settlement against Kansas physicians whose nonresident professional corporation carries liability insurance covering the settlement. The district court entered a declaratory order concluding the Act directs the Fund to make payments in this situation. Because the Kansas Supreme Court has construed the Act to the contrary, we reverse.

The Act requires every health care provider residing and licensed to practice medicine in Kansas to maintain a

specified minimum amount of professional liability insurance. Kan.Stat.Ann. §§ 40-3401(b), (f), -3402(a) (1986). The Act also provides the Fund will pay any portion of a malpractice settlement against a Kansas provider that exceeds the required minimum coverage. *Id.* § 40-3403(c)(1). "[I]f any liability insurance in excess of [the required minimum coverage] is applicable to [a settlement] or would be applicable in the absence of th[e] [A]ct," however, payments from the Fund are limited to "[the] excess [of the settlement amount] over [the] amounts paid [on the applicable liability insurance] or that would have been payable in the absence of th[e] [A]ct." *Id.* § 40-3408. During the period relevant to this appeal, the Act required minimum coverage of $100,000 for each occurrence of malpractice. *Id.* § 40-3402(a) (1976) (amended 1986).

Andrew B. Kaufman, M.D., and Robert A. Morantz, M.D., resided in Kansas and were licensed to practice medicine there. Both maintained professional liability policies with the Medical Protective Company (Medical Protective) that satisfied the Act's $100,000 minimum coverage requirement. Although not governed by the Act, the Missouri professional corporation that employed Kaufman and Morantz (the Corporation) also maintained a liability policy with Medical Protective. The Corporation's policy insured against up to $1,000,000 in damages resulting from "professional services rendered . . . [by any] person for whose acts or omissions the [Corporation was] legally responsible."

In 1983, Kaufman, Morantz, and the Corporation were named as defendants in a malpractice action. Medical Protective settled the claim on behalf of the doctors

and the Corporation for $715,000, charging $100,000 of the payment to the individual policies of Kaufman and Morantz, respectively, and $515,000 to the Corporation's policy. Medical Protective then sought a declaratory judgment that the Fund was liable for the $515,000 portion of the settlement exceeding the coverages of Kaufman and Morantz. The Fund replied that the Act prohibited payment, contending the Corporation's vicarious liability insurance was "applicable to [the settled] claim or would [have been] applicable in the absence of th[e] [A]ct." *Id.* § 40-3408 (1986).

The district court rejected the Fund's contention. Since the Corporation could recover the full amount of its vicarious liability from Kaufman and Morantz by asserting its rights to indemnity, the court concluded Kaufman and Morantz alone were primarily liable for the entire settlement payment. Based on this conclusion, the court determined "the vicarious liability coverage [carried by] the [C]orporation [was] not 'applicable' " liability insurance within the meaning of section 40-3408. The district court thus held the Act presented no barrier to the Fund's payment of the doctor's excess liability. 716 F.Supp. 392.

As a federal court interpreting a state statute, we are " 'bound by the construction given the statute by the highest court within the state' " that promulgated the measure. *Chandler v. Presiding Judge, Callaway County,* 838 F.2d 977, 979 (8th Cir.1988) (quoting *Slaaten v. Cliff's Drilling Co.,* 748 F.2d 1275, 1277 (8th Cir.1984) (per curiam); *see also Kansas State Bank v. Citizens Bank,* 737 F.2d 1490, 1496 (8th Cir.1984). Further, we apply the statutory construction in effect at the time we render our decision on appeal. *Demmer v. Patt,* 788 F.2d 1387, 1389 (8th Cir.1986).

In this instance, the Kansas Supreme Court recently held: (1) a nonresident professional corporation's vicarious liability insurance does constitute "applicable" coverage under section 40-3408; and (2) section 40-3408 bars payment from the Fund if that insurance is adequate to satisfy a settlement that exceeds the required minimum coverage of the corporation's liable employees. *Obstetrics & Gynecology Ltd. v. Buckner*, 247 Kan. 170, 178-179, 795 P.2d 386, 392-393 (1990). Given the Kansas Supreme Court's decision in *Buckner*, we must conclude the Act does not permit the Fund to make the contribution Medical Protective seeks.

Accordingly, we reverse the district court's order.

IN THE UNITED STATES DISTRICT COURT
FOR THE WESTERN DISTRICT OF MISSOURI
WESTERN DIVISION

THE MEDICAL PROTECTIVE COMPANY, Plaintiff,	)	Case No. 86-0569-CV-W-1
v.	)	FILED
FLETCHER BELL, Defendant.	)	MAY 10 1989

ORDER

This action for declaratory judgment has been submitted for resolution on the briefs as agreed by the parties. The parties filed their stipulation of facts on December 18, 1987. Plaintiff filed its trial brief on January 20, 1988. Defendant filed his trial brief on February 22, 1988. Plaintiff filed a reply brief on March 18, 1988. By letter dated August 17, 1988, defendant's counsel alerted the court to a recently decided case. Plaintiff's counsel responded to the letter in a letter dated September 7, 1988. On November 23, 1988, the court heard oral argument from the parties. For the reasons set forth below, the declaratory judgment sought by plaintiff will be entered in favor of plaintiff and against the defendant.

I. Statement of the Case

The plaintiff insurance company sued the defendant, who is administrator of the Kansas Health Care Stabilization Fund, to be indemnified for funds paid in excess of the coverage limits on two doctors. Specifically, the plaintiff wants to recover $515,000 paid in settlement of a

medical malpractice suit against two doctors and the professional corporation that employed them. Plaintiff alleges that the professional corporation's liability is purely vicarious and, thus, the corporation is entitled to indemnity from the employee doctors. As the insurer for the corporation, plaintiff is attempting to subrogate the indemnity claim. The plaintiff paid $200,000 under the policies it issued to the two doctors ($100,000 limit for each).

Plaintiff claims that any money paid beyond the policy limit should be paid by the fund, which is the excess carrier for the doctors, rather than under the professional corporation's policy. Defendant responds that the three policies issued to the two doctors and the corporation all apply before the fund's excess coverage would be payable. Defendant argues that the policies' coverage was not exhausted by the settlement, so no excess coverage was payable.

This case presents an intriguing combination of questions concerning choice of laws, contract construction, statutory construction, contract law, tort law, and insurance law. In reaching its conclusions, the court has been aided by exceptionally well-prepared briefs from both parties. This court's conclusions, in short, are: (1) Missouri law applies here except where Kansas law will be used to construe Kansas statutes. (2) The professional corporation's liability is vicarious, so it is entitled to indemnity from its employee doctors. (3) The plaintiff, as the corporation's insurer, may subrogate the indemnity claim and thus obtain reimbursement directly from the fund.

II. Statement of Facts

The plaintiff is incorporated in its principal place of business, Indiana, and is authorized to conduct insurance business in Missouri and Kansas. The defendant is the Kansas commissioner of insurance and as such is the administrator of the Kansas Health Care Stabilization Fund. The fund was created by the Kansas Health Care Provider Insurance Availability Act, Kan.Stat.Ann. § 40-3401 *et seq.* Andrew B. Kaufman, M.D., and Robert A. Morantz, M.D., are physicians licensed by the Missouri and Kansas Boards of Healing Arts. Both physicians resided in Kansas but were employed in Missouri by Arnold Schoolman, M.D., Ph.D., a Missouri professional corporation.

Under the Kansas statute, a health care provider who resides in Kansas carries insurance for at least $100,000 per occurrence. The Kansas fund then pays any amount of a judgment or settlement in excess of the basic $100,000 coverage, even if the alleged incidents occurred outside Kansas. However, if any liability insurance in excess of the $100,000 amount is. applicable to any claim, or would be applicable in the absence of the Kansas fund, "payments from the fund shall be excess over such amounts paid, payable, or that would have been payable in the absence of" the fund. Kan.Stat.Ann. § 40-3408.

Plaintiff issued separate policies of professional liability insurance to Drs. Kaufman and Morantz, each limited to $100,000 per occurrence. Plaintiff also issued a separate policy to the corporation, limited to $1,000,000 per occurrence. The three policies were in force during the relevant time. Also at that time, Drs. Kaufman and

Morantz were Kansas resident health care providers within the meaning of the Kansas Act.

A civil action, styled *Allen v. Morantz, et al.*, was filed on July 20, 1983, in Jackson County, Missouri, Circuit Court, wherein damages were sought from Drs. Kaufman and Morantz, and from the Schoolman corporation. Essentially the petition alleged medical malpractice concerning services rendered in Missouri by the two doctors within the course and scope of their employment by the Schoolman corporation.

On March 31, 1986, Gerald D. Ediger, territorial manager for plaintiff's law department, discussed the *Allen* case with Derenda J. Mitchell of the Kansas fund. Ediger demanded that the fund assume responsibility for all amounts sought from Drs. Kaufman and Morantz which exceeded the limits of the policies issued to them by plaintiff. Mitchell responded that the fund would pay only the excess over the combined limits for the three policies issued to Drs. Kaufman and Morantz and to the Schoolman corporation. The discussion was memorialized in a letter dated April 1, 1986, from Ediger to Mitchell.

Having been informed of the fund's intention not to contribute until the three policy limits were exhausted, plaintiff herein negotiated and entered a settlement of all claims against plaintiff's insureds (Kaufman, Morantz, and Schoolman corporation) on March 31, 1986. Plaintiff herein agreed to pay $715,000 under the coverage of the three policies. The amount includes the limit of $100,000 from each of the two doctors' coverage, and the remaining $515,000 from the coverage of the corporation. The

Kansas fund was not a party to the negotiations or to the settlement.

The plaintiff herein did not obtain the consent or agreement of the fund that the settlement payment would not be a waiver of any claim of the plaintiff against the fund. The release signed by the *Allen* plaintiff said Medical Protective, by tendering payment of sums in excess of the two doctors' insurance limits, was not assuming "volunteer status."

On March 31, 1986, plaintiff filed its original petition for declaratory judgment against defendant in Jackson County, Missouri, Circuit Court. The action was removed here by defendant Bell on May 2, 1988.

On April 11, 1986, the plaintiff herein paid $200,000 directly to the *Allen* case plaintiff and deposited the remaining $515,000 with the court administrator of Jackson County Circuit Court. On April 11, 1986, the circuit court directed the circuit court clerk to pay that amount to the *Allen* plaintiff.

The plaintiff herein is not seeking reimbursement and recovery from the fund for the $200,000 paid under the policies issued to Drs. Morantz and Kaufman. Rather, the plaintiff seeks reimbursement for the $515,000 paid pursuant to the policy issued to the Schoolman corporation. The fund has refused to provide coverage and/or indemnification for the $515,000, which is the amount by which payment exceeded the limit of coverage of the two doctors.

The fund has no independent knowledge upon which to ascertain the reasonableness of the *Allen* settlement

amount. However, the fund does not contest the reasonableness of the amount.

III. Discussion

A. Parties' Arguments

1. Plaintiff's Argument

The plaintiff's argument takes several steps to reach its conclusion that it is entitled to reimbursement of the settlement amount paid on behalf of the Schoolman corporation. To begin, plaintiff urges application of Missouri law which, plaintiff argues, supports its approach to the flow of liability and to the duty to pay. First, if the corporation is vicariously liable, then the corporation would pay damages exceeding the primarily liable physicians' coverage. Second, if the corporation pays, then it would be entitled to indemnity from its primarily liable employee physicians. Third, if the corporation is entitled to indemnity, then the physicians would reimburse the corporation. Fourth, if the physicians' insurance coverage is exhausted, the excess insurance carrier (the Kansas fund) would reimburse the corporation.

Plaintiff asserts that, as the corporation's insurer, it may subrogate the corporation's indemnity claim. If the plaintiff can subrogate, then the primarily liable physicians would reimburse the plaintiff for amounts paid by plaintiff on behalf of its insured corporation. If the physicians' basic coverage is exhausted, then the excess insurance carrier would reimburse the plaintiff.

2. Defendant's Argument

Defendant relies upon alternative theories, based upon his belief that Kansas law controls. First, the corporation is directly, not vicariously, liable for damages. If the corporation is directly liable, then it is not entitled to indemnity from the employee physicians. If the corporation cannot be indemnified, then the physicians' excess insurance would not apply and the corporation's own insurer (plaintiff) would pay the damages. Furthermore, the corporation is not covered by the Kansas statute, so the defendant would not be liable for excess coverage even if the corporation's basic coverage were exhausted.

Second, if the corporation is vicariously liable, then plaintiff still would pay the damages under the terms of its policy because plaintiff agreed to pay for vicarious liability. Further, even if the corporation were entitled to indemnity against the employee physicians, the plaintiff could not subrogate the corporation's indemnity claim. Plaintiff could not subrogate because the physicians also were insured by plaintiff and, defendant argues, an insurer cannot subrogate against its own insureds.

Third, even if the corporation were not required to pay damages on its direct or vicarious liability, defendant still would not be obligated to pay damages. That is, if the corporation paid a claim it was not required to pay, then the payment was voluntary and, as such, need not be reimbursed by defendant.

Fourth, even if the line of responsibility does reach the defendant, it need not pay because (a) defendant did not participate in the settlement negotiations, or (b) the

court has no jurisdiction over defendant to enforce payment, or (c) the Kansas statute does not permit such a payment, or (d) to construe the statute to require such a payment would achieve an unfair or absurd result which could not have been intended by the Kansas legislature.

B. Choice of Laws

The analysis must begin with where Missouri law applies and where Kansas law applies. It is significant that the underlying acts occurred in Missouri, involving physicians practicing medicine in Missouri, employed by a Missouri corporation, all of whom were insured first under policies written to protect against risk in Missouri. Also it is significant that the physicians (but not the Missouri corporation) are subject to Kansas statute regarding the fund, the fund was created by Kansas statute, the fund's rights, duties and obligations arise from Kansas statute, and Kansas courts have construed the Kansas statute.

The conflict-of-laws rules of the forum state control which substantive law should apply. *Jump v. Goldenhersh*, 619 F.2d 11, 13 (8th Cir. 1980) . A federal district court sitting in Missouri is bound to follow the choice-of-law rules of Missouri. *Ryder Truck Rental, Inc. v. U. S. Fidelity and Guar. Co.*, 527 F.Supp. 666, 670 (E.D. Mo. 1981). Therefore, Missouri rules control the choice of laws.

In *Kennedy v. Dixon*, 439 S.W.2d 173, 184 (Mo. 1969), the Missouri Supreme Court adopted the "most significant relationship" test set forth in the *Restatement (Second) on Conflicts of Law*, § 145 to ascertain choice of law. Section 145 provides:

> 1. The rights and liabilities of the parties with respect to an issue in tort are determined by the local law of the state which, as to that issue, has the most significant relationship to the occurrence and the parties and the principal stated in § 6.
>
> 2. Contacts to be taken into account in applying the principals of § 6 to determine a law applicable to an issue include: (a) the place where the injury occurred, (b) the place where the conduct causing the injury occurred, (c) the domicile residence, nationality, place of incorporation and place of business of the parties, and (d) the place where the relationship, if any, is centered. These contacts ought to be evaluated according to the relative importance with respect to that particular issue.

Section 6 provides:

> (1) The court, subject to constitutional restrictions, will follow a statutory directive of its own state on choice of law.
>
> (2) When there is no such directive, the factors relevant to the choice of the applicable rule of law include (a) the needs of the interstate and international systems, (b) the relevant policies of the forum, (c) the relevant policies of other interested states and relevant interests of those states in the determination of the particular issue, (d) the protection of justified expectations, (e) the basic policies underlying the particular field of law, (f) certainty, predictability and uniformity of the result, and (g) ease in the determination and application of the law to be applied.

Applying this test, there can be no doubt Missouri law controls the underlying tort action. All the significant contacts are in Missouri: Place of injury, conduct causing

injury, place of incorporation, place of business, center of relationship. The only Section 145 item which is not in Missouri is the physicians' domicile, but the place of residence is not significant to the underlying tort action here. Consequently, Missouri tort law controls the chain of liability for the predicate personal injury claim.

In regard to contract questions, the *Restatement (Second)* also applies. *Havenfield Corporation v. H & R Block*, 509 F.2d 1263, 1267 (8th Cir.), *cert. denied*, 999 U.S. 421 2395 (1975). In *Ryder Truck Rental Inc. v. U.S. Fidelity and Guar. Co.*, *supra*, at 671, the court relied upon Sections 193 and 188 to determine the choice of law in a declaratory judgment action on liability insurance contract issues. Section 188 provides that in the absence of an effective choice of law by the parties, issues concerning the rights and duties under a contract are determined by the local law of the state which has the most significant relationship to the transaction of the parties under the principles stated in Section 6. The principles in section 188 can be applied to Section 193, according to Comment a, Section 193. Section 193 expressly applies to "contracts of fire, surety or casualty insurance" and provides:

> The validity of a contract of fire, surety or casualty insurance and the rights created thereby are determined by the local law of the state which the parties understand was to be the principal location of the insured risk during the term of the policy, unless with respect to the significant issue, some other state has a more significant relationship under the principals stated in § 6 to the transaction of the parties, in which event the local law of the other state will be applied.

In Comment c, § 193, the *Restatement* further explains that the law of the state of the "Principal location of the insured risk" should apply because "the state where the risk will be principally located during the term of a policy has a natural interest in the determination of issues arising under the insurance contract."

There appears to be no dispute, at least regarding plaintiff's coverage of the two physicians and corporation, that the principal location of insured risk is Missouri. The physicians were providing services in Missouri while employed by a Missouri corporation, so the law of Missouri should govern insurance contract issues here in regard to plaintiff's coverage of the physicians and corporation.

Missouri law also applies to the fund's coverage, even though the fund is created and operated by Kansas statute. Certainly, the fund's rights and duties arise from a Kansas statute, rather than from a traditional insurance contract. Yet, the fund effectively is an excess insurance carrier, by providing coverage in excess of the basic limits required and administered by the commissioner of insurance. *Stephens v. Snyder Clinic Ass'n*, 230 Kan. 115, 631 P.2d 222, 226 (Kan. 1981). The statute required resident health care providers to carry approved basic coverage of $100,000, while undertaking to pay the excess for a judgment or settlement. The provision for paying the excess is not limited to claims arising in Kansas. Section 40-3403(c)(1), Kan.Stat.Ann., provides:

> * * * [T]he fund shall be liable to pay: (1) Any amount due from a judgment or settlement which is in excess of the basic coverage liability of all liable resident health care providers or

> resident self-insurers for any personal injury or death arising out of the rendering of or the failure to render professional services *within or without [Kansas]*.

(emphasis added). Judgments or settlements in an outside state, obviously, would occur according to the laws of that outside state. If Missouri were the outside state, its laws of insurance would control. Certainly the Kansas legislature could not have presumed it had authority to change Missouri insurance contract law, even when the legislature was providing excess coverage for Missouri injuries. Missouri law applies to liability insurance issues here, regardless of whether the excess insurance is rooted in contract or statute.

Upon establishing the rights, duties and liabilities of the parties under applicable Missouri law, the effect of the Kansas statute must be examined. Just as the Kansas legislature cannot change Missouri law, a court sitting in Missouri cannot change Kansas statutes. Rather, application of Kansas statutes includes application of the Kansas case law construing those statutes. *See Osterholt v. St. Charles Drilling Co.*, 500 F.Supp. 529, 533 (E.D.Mo. 1980) (federal district court sitting in Missouri interprets Illinois statute according to Illinois case law). Further, federal courts look to the decisions of the highest court of the state as the final authority on state law. *R.W. Murray Co. v. Shatterproof Glass Corp.*, 697 F.2d 318, 827 (8th Cir. 1983). Therefore, when the operation of the Kansas statute enters the analysis of this matter, it must be as construed by Kansas courts.

C. Vicarious Liability

The liability of the two physicians is not in question, so the analysis begins with the liability of the employer corporation. As noted above, plaintiff argues that the corporation's liability is purely vicarious. Defendant responds that the complaint in the underlying state tort action did not specify that the liability was vicarious, therefore the corporation is directly liable as a principal with the physicians. Alternatively, defendant argues that even if liability is vicarious, plaintiff must pay damages because its policy covered vicarious liability. Plaintiff replies that the complaint in the tort action did not specify that the liability was direct or vicarious, so no conclusion can be drawn on that basis.

Defendant's argument that the corporation is directly liable is untenable. As a fictional entity created and existing only in contemplation of law, a corporation cannot act through its own efforts. The only way corporations can act in the commission of wrong or otherwise is by and through their agents. *Perkins v. Missouri K. & T. R.R.*, 55 Mo. 201, 214 (1874) The sole manner in which such a legal entity could be liable in tort would be through some agent or employee. *Presley v. Central Terminal Co.*, 142 S.W.2d 799, 803 (Mo.App. 1940). In *Presley, id,* exoneration of an employee in an assault claim necessarily was exoneration of the corporation. In *Roberts v. Wayne,* 624 S.W.2d 523, 525 (Mo. App. 1981), a health care corporation which was named in a medical malpractice action with a surgeon could not be found liable unless the surgeon was found liable. *See also, Standard Meat Co. v. Taco Kid of Springfield, Inc.*, 554 S.W.2d 592, 595 (Mo.App. 1977), wherein a defendant corporation could not be liable

unless the [sic] its agent was found liable. There can be no doubt that any liability by the Schoolman corporation in the underlying tort action is vicarious, predicated solely upon liability of its agents/employees, the physicians.

Defendant relies heavily upon *McGuire v. Sifers*, 235 Kan. 368, 681 P.2d 1025, 1034 (1984), wherein a professional corporation was held liable with employee physicians for the physicians' negligence. Liability was found on theory of respondeat superior which, by definition, is vicarious liability. The court apparently was relying upon the Kansas legislature's awareness of respondeat superior, as illustrated by its statement at 1034:

> If the legislature had intended to abrogate the doctrine of respondeat superior as to professional corporations, it could have done so through the enactment of specific and definitive legislation. But, it did not do this.

(Curiously, the legislature later enacted Kan.Stat.Ann § 40-3403(h) (Supp. 1986), eliminating vicarious liability for the actions of health care providers. Section 40-3403(h) also provides it "shall apply to all claims filed on or after the effective date of this act.") Although interesting, *McGuire* is not controlling on the vicarious liability issue because (1) Missouri law applies here and (2) the Schoolman corporation (a Missouri resident) is not a resident health care provider within the ambit of the Kansas statute. In any event, the case is consistent with the finding here that the Schoolman corporation is vicariously liable under the terms of the underlying tort action and settlement of it.

D. Indemnity

Defendant argues that the Schoolman corporation (and, hence, the plaintiff insurer of Schoolman) is not entitled to indemnity from the employee/physicians. He argues that the Kansas statute does not provide for such indemnity payments, and that a decision to that effect would be a result which is unreasonable and unintended by the Kansas legislature. He further argues that finding an indemnity right effectively would afford more protection to nonresident health care providers than to Kansas resident health care providers. Finally, defendant argues that a premium was paid to plaintiff to provide coverage for vicarious liability, and plaintiff should be held to that obligation.

As stated above, Missouri law applies to the indemnity issue. Missouri law provides that where an agent acting within the scope of his employment subjects his principal to liability because of a negligent act, the agent is liable to the principal for the resulting loss in the form of damages paid by the principal to a third person. *See, State ex rel. Algiere v. Russell*, 359 Mo. 800, 223 S.W.2d 481, 483 (Mo. 1949). In *Russell*, the Missouri Supreme Court stated that:

> Unless he has been authorized to act in the manner in which he acts, the agent who subjects his principal to liability because of a negligent or other wrongful act is himself subject to liability to the principal for the loss which results therefrom. This includes the payment of damages by the principal to the third person, or of a fine to the State in case of a crime. Thus, the servant who, while acting within the scope of

> his employment, negligently injures a third person, although personally liable to such person, is also subject to liability to the principal if the principal is thereby required to pay damages.

Id. at 483, quoting *Restatement of Agency* § 401, Comment c. In other words, a corporation which pays damages to a third person who was injured by a corporate employee is entitled to indemnity from the employee. Perhaps it is interesting, although not relevant, that Kansas has the same doctrine. *See Fenly v. Revell*, 170 Kan. 705, 228 P.2d 905, 907-908 (1951), citing numerous cases and treatises on that point.

Defendant's first argument is simply incorrect because, under Missouri (and Kansas) law, a principal may claim indemnity from its agent. Second, the provisions of the Kansas statute are not relevant at this stage in the analysis because, as stated above, Missouri law is applied first to determine the path of liability. After the path of liability is plotted, the source of coverage for that liability can be examined. Third, even if finding indemnity for a Missouri corporation would be an unintended advantage to nonresident corporations, that is a consequence which should have been foreseen when the Kansas legislature provided for excess coverage for out-of-state torts.[1] Certainly the legislature did not believe that,

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[1] Indeed, with the subsequent statutory elimination of respondeat superior in Kansas, a Kansas health-care provider would have an unfair advantage over the nonresident provider if defendant's theory would be used. Defendant would preclude indemnity for a nonresident corporation on its vicarious liability for Kansas health-care providers' acts, even while Kansas professional corporations would be exempt from liability for Kansas health-care providers' acts.

by passing the statute, it could change the history, policies, statutes and case law of tort liability in other states.

Finally, defendant's argument about plaintiff's obligation cannot stand. The statute imposes upon the fund an obligation to pay excess claims, in return for the requirement that doctors carry their own basic coverage (under Section 40-3402) and pay into the fund for excess coverage (under Section 40-3404). The fund, under the statute, is no less obligated to honor its excess coverage than the plaintiff is obligated to honor its vicarious liability coverage.

E. Subrogation

The right, if any, of subrogation probably is the linchpin of this case. Even if there were no dispute about the issues discussed above, plaintiff could not prevail if it could not subrogate the Schoolman corporation's rights of indemnity against the employee/physicians – who also were insured by plaintiff. Defendant argues that an insurer cannot subrogate against its own insureds.

In support of its argument, defendant relies upon the Kansas statute and various cases. The statute, as suggested above, will be set aside for now until the chain of liability under Missouri law is resolved. The cases, on the other hand, will be examined because of their persuasive policy reasons to prevent an insurer from subrogating against its own insureds. Defendant quotes *Couch on Insurance* 2d § 61:133:

> No right of subrogation can arise in favor of the insurer against its own insured, since by definition subrogation arises only with respect to the

> rights of the insured against third parties to whom the insurer owes no duty.

Defendant also relies upon *Frank Briscoe Co. v. Georgia Sprinkler Co.*, 713 F.2d 1500, 1502 (11th Cir. 1983); *Stetina v. State Farm Mutual Auto Ins. Co.*, 194 Neb. 441, 243 N.W.2d 341, 346 (Neb. 1976) and *Moring v. State Farm Mut. Auto. Ins. Co.*, 426 So.2d 810, 812 (Ala. 1982). Most similar to the facts at hand, however, is *Continental Casualty Co. v. Empire Gas Co.*, 713 P.2d 384 (Colo.App. 1984)[2] where the insurer issued separate policies of professional liability insurance to a doctor and to his professional corporation. After a medical malpractice action against the doctor and the professional corporation had been settled, the insurer asserted that all insurance coverage of the doctor had to be exhausted before any coverage available to the professional corporation could be reached. The court, at 394, rejected the insurer's argument that it should be subrogated to the corporation's right of indemnity against the physician employee. The court said, at 394:

> To allow subrogation under such circumstances would allow an insurer, in effect, to pass the

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[2] Only dubious efficacy can be attributed to the *Continental Casualty* case. It was overruled on November 28, 1988, in *Lininger v. Eisenbaum*, 764 P.2d 1202, 1210 (Colo. 1988). The Colorado Supreme Court held that there was no cause of action for wrongful life, which was the gravamen of *Continental Casualty*. The court said *Continental Casualty* was overruled only to the extent that it was inconsistent with the later decision. Technically, perhaps, the subrogation holding thereby was left intact. However, having overruled *Continental Casualty* on the preliminary matter of whether a cause of action existed, there would be no need to consider if rights in such action could be subrogated.

> incidence of the loss, either partially or totally, from itself to its own insured, and thus avoid the coverage which its insured purchased.

See also. Home Ins. Co. v. Pinski Bros. Inc., 160 Mont. 219, 500 P.2d 945, 949 (1972). In other words, the insured would receive no protection in exchange for his premium because it still would be liable to his insurer for payments on claims.

The court in *Pinski Bros., supra* at 949, presented an interesting survey of the mischief which could be caused by permitting an insurer to subrogate against its own insured:

> Such action, if permitted, would (1) allow the insurer to expend premiums collected from its insured to secure a judgment against the same insured on a risk insured against; (2) give judicial sanction to the breach of the insurance policy by the insurer; (3) permit the insurer to secure information from its insured under the guise of policy provisions available for later use in the insurer's subrogation action against its own insured; (4) allow the insurer to take advantage of its conduct and conflict of interest with its insured; and (5) constitute judicial approval of a breach of the insurer's relationship with its own insured.

The court further noted, at 949, that subrogation is an equitable principle and, accordingly, certain equitable principles apply in determining subrogation rights: (1) One who seeks equity must do equity. (2) One who seeks equity must come into court with clean hands. (3) No one can take advantage of his own wrong. Subrogation, as a principle of equity, also was examined in *Fenly v. Revell, supra*, 228 P.2d at 910: "[L]egal subrogation does not

depend upon contract or assignment but follows as the legal consequence of the acts and relationship of the parties."

Surprisingly, however, the foregoing discussion compels a conclusion that plaintiff is entitled to subrogate in the peculiar circumstances presented here. The significant facts are (1) plaintiff undertook to pay $100,000 per occurrence for each of the two doctors, (2) plaintiff paid $100,000 for each of the two doctors, (3) by doing so, plaintiff discharged its obligation – for which premiums were paid – to the two doctors, (4) plaintiff is not seeking reimbursement for the $200,000 but, rather, the $515,000 paid for the Schoolman corporation's vicarious liability.

In light of the legal consequence of those acts, and the relationship of the parties, the two doctors effectively became third parties relative to the plaintiff for purposes of this action. The doctors effectively became third parties because plaintiff no longer owed a duty to them. The effect was the same as if some insurer other than plaintiff had paid on the basic coverage, and plaintiff was proceeding against unrelated third parties. By subrogating the Schoolman corporation's indemnity right, plaintiff would not be evading its obligation to the employee doctors. Rather, plaintiff is merely exercising its subrogation rights under the Schoolman corporation policy.

Interestingly, this view is consistent with a recent Kansas Supreme Court case. In *Western Motor Co., Inc. v. Koehn*, 242 Kan. 402, 748 P.2d 851, 853 (1988), the court reviewed the general rule against subrogating against one's own insured. The court then said, at 853:

> Therefore, to determine whether an insurer is barred from claiming a right of subrogation against a particular person, the insurance contract must be examined to determine whether it was the intention of the parties to include the person within the scope of the policy's coverage.

In the case at hand, examination of the insurance contracts reveals the scope of the policies' basic coverage for the doctors was limited to $100,000 each. Therefore, upon paying the limits of coverage, plaintiff was not precluded from claiming a right of subrogation against the doctors for the amounts exceeding those limits.

Significantly, this result is consistent with the purpose of the rule that precludes an insurer from subrogating against its own insureds. As stated above, subrogation is a principle of equity. In this instance, plaintiff has done equity by paying on the doctors' coverage. The plaintiff has come with clean hands, and does not seek to take advantage of its own wrong. More important, however, none of the mischief described in *Pinski Bros., supra,* would occur. The insurer would not be securing a judgment on the risk which it insured against (it already paid on that risk). There would be no breach of the doctors' policies (plaintiff already performed). Information obtained from the doctors is not being used to get a judgment against them. The insurer would not be taking advantage of its conduct and conflict of interest with the doctors (the conduct fulfilled plaintiff's duty, so the conflict was extinguished.) There was no breach for which judicial approval would be obtained.

In equity, the doctors should (and did) receive the full limits of coverage on their policies while retaining

responsibility for indemnifying their employer. The plaintiff should be (and was) obligated to pay the full coverage on the doctors, while retaining the right to subrogate the Schoolman corporation's right to indemnity on its vicarious liability. The fund, as an excess carrier, should be liable for the excess coverage due from its insureds (the doctors) to whomever (the corporation and hence the plaintiff) the excess coverage is due.

Support for this finding can be found in *Commercial Union v. Chubb Group of Ins. Cos.*, 194 N.J.Super. 290, 476 A.2d 290, 296 (N.J.Super.Ct.App.Div. 1984), Brody, J. dissenting, majority opinion reversed, 499 A.2d 1362 (N.J.1985)(adopting reasoning of Brody dissent). The facts in that case are remarkably similar to the facts here. In the opinion which was adopted by the New Jersey Supreme Court, Judge Brody said, 476 A.2d at 296-297:

> * * * Where one liability policy covers an employee for his own negligence and another covers his employer for the same negligence, the employee's policy must first be exhausted before the employer's carrier may be called upon to pay. This reflects the common-law rule that a negligent employee must indemnify his employer whose liability is only vicarious. *Maryland Cas. Co. v. N.J. Mfrs. &c., Ins. Co.*, 48 *N.J.Super.* 314, 327-328, 137 A.2d 577 (App.Div.1958), aff'd 28 *N.J.* 17, 145 A.2d 15 (1958). Here that indemnification is implemented by a clause in the corporation policy wherein Chubb is "subrogated to all the insured's rights of recovery against any person. . . . "
>
> In my view if Chubb had paid the injured party in response to the corporation's vicarious

> liability coverage, it would be entitled to indemnification from Commercial for so much of the payment as exceeded the doctor's basic malpractice coverage under Chubb's individual policy. To avoid a "circuity of action," the Chubb policy covering the doctor individually for malpractice and Commercial's excess policy which expands his individual malpractice coverage must pay the injured party before the Chubb corporation policy is called upon to pay for the corporation's vicarious liability. *See Maryland Cas. Co. v. N.J. Mfrs. &c., Ins. Co., supra,* at 328, 137 A.2d 577. * * *

The Kansas City Court of Appeals also considered the rule precluding subrogation against one's own insured, and held the rule did not apply where subrogation was brought against a co-insurer rather than the insured. In *State Farm Mut. Auto. Ins. Co. v. Central Sur. and Ins. Corp.*, 405 S.W.2d 530 (Mo.App. 1966), plaintiff and defendant both had written coverage. Defendant refused to defend its insured, and asserted it was liable only for any excess above plaintiff's coverage of insured. Plaintiff filed suit against the co-insurer defendant to obtain pro rata reimbursement, after paying the full settlement amount. The court said, at 535:

> The facts in this case are very similar to those in Liberty Mutual Ins. Co. v. Standard Accident Ins. Co. (U.S.D.C.S.D.N.Y.), 164 F.Supp. 261 [1958]. In that case both plaintiff and defendant had issued policies to the same insured. Each policy contained similar clauses concerning "other insurance" and "subrogation". That is also true in the instant case. On pages 263 and 264, the court said:
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> " * * * The amount paid in settlement fixes the amount or the loss which the co-insurers

must share. True the amount paid must be reasonable, cf. Royal Indem. Co. v. American Cas. Co., 5 Misc.2d 533, 159 N.Y.S.2d 45, but the fact that the payment was less than the judgment is prima facie proof of its reasonableness. Plaintiff by virtue of its payment and under the terms of the subrogation clause, was subrogated to all rights which the insured would have against defendant. If the insured had made the settlement and the payment after the defendant's disclaimer of coverage, defendant would have been liable to the insured for its share of the settlement payment. Defendant is similarly liable to plaintiff under the terms of the subrogation clause. This conclusion is in accord with Commercial Standard Ins. Co. v. American Emp. Ins. Co., 6 Cir., 209 F.2d 60. See also United States Guarantee Co. v. Liberty Mut. Ins. Cas., 244 Wis. 317, 12 N.W.2d 59, 150 A.L.R. 632; Detroit Auto. Inter-Ins. Exchange v. Detroit Mut. Auto Ins. Co., 337 Mich. 50, 59 N.W.2d 80."

In United States Guarantee v. Liberty Mut. Ins. Co., 244 Wis. 317, 12 N.W.2d 59, 150 A.L.R. 632, 636, the court said:

"* * * The plaintiff by and under its contract with assured agreed 'to pay on behalf of the insured all sums which the insured shall become obligated to pay by reason of the liability imposed upon him by law for damages * * *'. In paying the damages to Gaurkee it performed the terms of its contract with the assured, as the defendant had breached and violated its contract for a like liability. By the terms of its policy plaintiff was subrogated to the rights of the assured which, under the decisions, is a substitution of one person in the place of another with reference to a lawful claim or right. It is a device adopted or invented by equity to compel the ultimate discharge of a debt or obligation by one who in good conscience ought to pay it. Leonard

> v. Bottomley, 1933, 210 Wis. 411, 245 N.W. 849; Northern Assurance Co., Ltd. v. [City of] Milwaukee, 1938, 227 Wis. 124, 277 N.W. 149. If assured had made settlement with Gaurkee and was the plaintiff in this action, defendant would be liable for the amount now claimed. By payment of the entire amount, plaintiff is substituted in place of the assured with reference to a lawful claim or right. When defendant violated the contract by refusing to defend the Gaurkee action, a settlement by plaintiff and payment of the full damages did not make plaintiff a volunteer or interloper as to the payment for which this defendant is liable. * * * "
>
> In State ex rel. McCubbin v. McMillian, (Mo.App.), 349 S.W.453, 1. c. 459 and 460, and 461, the court reached the same result as is stated in the above decisions.

Consider the obvious similarity to the case at hand. Plaintiff was obligated to coverage of $100,000 on each of the doctors, and the defendant's fund was obligated to pay the excess. That is, the fund was, "in effect, an 'excess' insurance carrier, providing coverage in excess of the basic required limits administered by the Commissioner of Insurance. . . . " *Stephens v. Snyder Clinic Ass'n*, 230 Kan. 115, 631 P.2d 222, 226 (1981). So, plaintiff and defendant effectively were co-insurers of the doctors. If the doctors had been compelled to indemnify the Schoolman corporation for payments on its vicarious liability, the fund would have been required to pay amounts exceeding $100,000 for each of the doctors. Rather than engage in a "circuity of action," plaintiff brought this action directly against the co-insurer. The plaintiff seeks reimbursement of that to which the Schoolman corporation is entitled by indemnity, that is, the amount of the

settlement in excess of the doctors' basic coverage. Under *State Farm Mut. Auto. Ins. Co. v. Central Sur. and Ins. Corp., supra,* plaintiff may bring such an action by subrogating the Schoolman corporation's claim for indemnity against the doctors.

F. Kansas Statute

Upon determining the flow of liability under Missouri law, the provisions of the Kansas Health Care Provider Insurance Availability Act (Kan.Stat.Ann. §§ 40-3401 *et seq.*) must be examined. During the relevant period, the fund required a professional liability insurance policy to be maintained by "each resident health care provider as a condition of rendering professional services. . . . " Kan.Stat.Ann. § 40-3402(a). The requirement was that the policy be approved by the defendant, issued by a duly authorized insurer, and cover at least $100,000 per occurrence. *Id.*[3] The definition of a "health care provider" includes certain persons licensed by the Kansas State Board of Health Arts to practice certain of the healing arts. Kan.Stat.Ann. § 40-3401(f). The parties stipulated that Drs. Kaufman and Morantz were resident health care providers under the statute. Of course, Schoolman, a Missouri corporation, is not a Kansas resident.

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[3] Currently the statute provides that a health care provider must carry coverage of at least $200,000 per occurrence. Kan.Stat.Ann. § 40-3402(a) (Supp. 1985).

Under Section 40-3403(c), the fund

> * * * shall be liable to pay (1) any amount due from a judgment or settlement which is in excess of the basic coverage liability of all liable resident health care providers or resident self-insurers for any personal injury or death arising out of the rendering of or the failure to render professional services within or without [Kansas]; (2) . . . in no event shall the Fund be obligated for claims against nonresident health care providers or non resident self-insurers who have not complied with this act or for claims against nonresident health care providers or non-resident self-insurers that arose outside of [Kansas].

The terms of the statute demonstrate that the fund would be liable for the excess claims against the resident doctors, but not the Schoolman corporation. However, defendant relies heavily upon another statutory provision. He states that Section 40-3408 specifically prohibits payment by the fund in this situation. Section 40-3408 provides:

> The insurer of a health care provider covered by the fund or self-insurer shall be liable only for the first $200,000 [previously $100,000] of a claim for personal injury or death arising out of the rendering of or the failure to render professional services by such health care provider, subject to an annual aggregate of $600,000 for all such claims against the health care provider. *However, if any liability insurance in excess of such amounts is applicable to any claim or would be applicable in the absence of this act, any payments from the fund shall be excess over such amounts paid, payable or that would have been payable in the absence of this act.* * * *

(emphasis added by defendant).

Contrary to defendant's argument, the terms of Section 40-3408 do not preclude payment of the excess here. As discussed above, the liability must be allocated according to Missouri law. Also as discussed above, the Schoolman corporation is entitled to indemnity under Missouri law. such entitlement exists under Missouri law regardless of whether the Kansas statute exists. Therefore, even in the absence of the act, the Schoolman corporation would be entitled to indemnity. Even in the absence of the act, the primarily liable doctors would be liable for reimbursement to the corporation (or its insurer, by subrogation). when the basic coverage was exhausted, the corporation (or its insurer, by subrogation) may call upon the excess carrier to pay the excess. In this instance, the excess carrier is the Kansas fund.

Defendant argues that the fund need not pay because the vicarious liability coverage for the corporation is "applicable." However, this argument overlooks the fact that the doctors are primarily liable, and the corporation is only secondarily liable. The corporation's coverage applies only if there is insufficient coverage for the doctors. In this instance, there is sufficient coverage. The basic coverage provided by plaintiff provides the first $200,000 toward satisfying the settlement. Then the excess carrier (the fund) would provide the excess.

The plaintiff would be required to pay on the corporation's vicarious liability only if (1) the limit of the excess coverage is reached or (2) the excess carrier did not fulfill its obligation to pay an excess claim. As revealed by the discussion above, the excess carrier for the primarily liable doctors is required under Missouri law to pay toward the settlement before the vicariously

liable corporation. By statute, the fund undertakes to provide such excess coverage for Kansas resident health care providers on claims arising outside Kansas. Because the Kansas statute could not presume to change Missouri law of liability, the excess coverage for the primarily liable doctors is payable before the vicarious liability coverage is payable. Therefore, the vicarious liability coverage for the corporation is not "applicable" before the fund's excess coverage.

The statute defines "applicability" in terms of "the absence of the statute." That is, the statute looks to what coverage would apply if the statute, and hence the fund, did not exist. At first glance, it might appear that without the statute and the fund, plaintiff would pay under its vicarious liability coverage of the corporation because the doctors would have no excess coverage. However, as stated above, the doctors would be liable to indemnify the plaintiff for payments made on behalf of the corporation. This would be so even in the absence of the statute. Conceivably, the doctors might be compelled to reimburse the plaintiff from their own assets for payments made on behalf of the corporation. Therefore, the vicarious liability coverage for the corporation is not "applicable." Because that coverage is not applicable, the statute does not preclude payment of excess coverage.

Indeed, the statute, in Section § 40-3403(c), requires payment of excess claims for resident health care providers. That requirement is just as clear as the prohibition against paying claims against nonresident health care providers, such as the schoolman corporation. Therefore, it is important to recognize that the fund's obligation is to

the doctors, not the corporation, even though the corporation (and its insurer, the plaintiff) benefits indirectly.

Defendant argues that this result would be an absurd result that could not have been intended by the Kansas legislature because it is more advantageous to Missouri professional corporations than to Kansas corporations. This argument fails for four reasons. First, Missouri law, not the Kansas statute, establishes the liability of the excess carrier. Second, the advantage to the professional corporation is merely an incidental (although substantial) consequence of the fund fulfilling its obligation to its insureds, the doctors. Third, the statute requiring payment of excess claims for residents is just as forceful as the statute prohibiting payment of claims against nonresidents. Fourth, the same result would occur if the resident doctors did not work for a professional corporation in any state; that is, the excess would be paid regardless of whether any corporation could benefit indirectly.

As an interesting sidelight, the result here apparently would not be an absurd or unintended application of Kansas statute. Shortly after defendant's main case, *McGuire v. Sifers, supra,* was decided, the legislature specifically eliminated respondeat superior liability for health care providers. That change would reverse the result in *McGuire,* and would achieve the same benefit for Kansas professional corporations as for those of Missouri, i.e., neither would be liable. So, if Schoolman were a Kansas corporation, it would be treated the same under the new statute as it will be treated in this case.

G. Miscellaneous Arguments

1. Solo Settlement and Voluntary Payment

Defendant argues that the fund is not obligated to pay part of a settlement which he did not negotiate. The facts are, however, that the plaintiff called upon its co-insurer, the fund, to defend its excess coverage position and pay on the excess claim. The defendant refused, so he cannot now be heard to avoid contribution to the settlement on the grounds that he did not participate in negotiating it. Indeed, the defendant has stipulated that he has no basis for doubting the reasonableness of the settlement.

Likewise, defendant argues that plaintiff's payment was voluntary, despite what defendant calls a "self-serving" disclaimer in the settlement agreement. The agreement recites that the payment was not voluntary. The plaintiff contended at the outset that its co-insurer, the fund, was liable. Upon the fund's refusal to pay, plaintiff proceeded to settle the litigation and pay the claim. There is no indication that, by paying the claim, plaintiff intended to waive its action against the defendant. Actually, its dealings with the defendant demonstrate the contrary. Under such circumstances, the payment was not voluntary and it is reimbursable. *See, United Services Auto. Ass'n v. United States Fidelity and Guar. Co.*, 555 S.W. 2d 38, 44 (Mo.App. 1977).

2. Contract Construction of Kansas Act

Defendant argues that, contrary to plaintiff's assertion, the Kansas statutes concerning the fund should not

be treated like a private insurance contract. To that extent defendant is correct. The statutes are not a contract, even though they create and regulate a proprietary activity, i.e., insurance. As discussed above, they are Kansas statutes and, as such, should be construed as statutes according to the decisions of Kansas courts. The argument is moot, however, because the path of liability under Missouri law leads to excess coverage by the fund before the analysis turns to construction of the Kansas statutes.

3. Personal Jurisdiction

Defendant argues that this court has no personal jurisdiction over him. The contention was examined at length and rejected in an opinion issued by the late Honorable Ross T. Roberts, United States District Judge, on November 3, 1986. The matter need not be reexamined here.

4. Direct Action Against Fund

Defendant argues that payment by the fund is precluded by Section 40-3412. That provision prohibits direct action by a claimant against the fund. In this instance, plaintiff is not a claimant. Rather, plaintiff is a co-insurer seeking reimbursement of some proceeds it paid to the claimant. The claimant, of course, was the plaintiff in the underlying tort action. This lawsuit is not limited by Section 40-3412 because it is not a direct action by a claimant against the fund.

5. Plaintiff's Obligations

Defendant argues that plaintiff is obligated for the full amount of coverage for which it drew premiums from its insureds. He relies upon *Missouri Medical Ins. Co. v. Wong*, 234 Kan. 811, 676 P.2d 113, 122 (1984), where the court found the basic insurance carrier liable for the full $1,000,000 of coverage it had written. In this instance, the plaintiff was obligated to a limit of $100,000 per doctor on the basic coverage, and plaintiff paid that obligation. If the limit of basic coverage had been $1,000,000, as it was in *Wong*, then the fund would not be liable on its excess coverage of the doctors until that higher limit was exhausted. However, the lower $100,000 limit was exhausted in this case and, at that point, the excess coverage was payable. Contrary to defendant's argument, the $1,000,000 vicarious liability coverage of the Schoolman corporation is irrelevant until both the basic coverage and excess coverage on the primarily liable doctors are exhausted.

Another problem with defendant's argument is that, under the Kansas statute, the fund also has an obligation to its insureds. The fund's statutory obligation to its insureds is just as forceful as the plaintiff's contractual obligation to its insureds. The fund's obligation under its excess coverage of primarily liable insureds is just as forceful as plaintiff's obligation under its basic coverage of primarily liable insured. The fund's obligation also is just as forceful as plaintiff's obligation under its coverage for vicarious liability. The difference, as examined above, is the order in which the obligations are aligned. Here,

the fund's obligation to pay under vicarious liability coverage arises only after the fund fulfills its obligation to pay under excess coverage of the doctors.

VI. Conclusion

In addition to the foregoing discussion, several considerations support a finding in favor of plaintiff here. First, it provides for equal treatment of Missouri and Kansas professional corporations. That is, any vicarious liability attributable to them would be payable only after the fund's excess coverage of primarily liable employees is exhausted. (Of course, Kansas professional corporations currently have no respondeat superior liability for acts of health care providers.)

Second, this ruling gives the plaintiff the benefit of its bargain by obligating it to pay on vicarious liability only after exhaustion of excess coverage of the primarily liable employees. Logic commands that the decision to purchase a $100,000 limit on basic coverage for the doctors – the same as required by the Kansas statute – was more than happenstance. If the fund were not required to pay under the excess coverage of the doctors, the plaintiff likely would have considered that (perhaps requiring additional basic coverage for the doctors) when it wrote the vicarious liability coverage for the corporation. The Missouri insurance coverage of a Missouri corporation for risk in Missouri would anticipate application of Missouri law concerning liability, indemnity and subrogation. This ruling applies Missouri law in those areas, thus giving plaintiff the benefit of its bargain.

Third, this ruling also enforces the obligation which the Kansas legislature imposed on the fund by statute. Upon enacting the statute, the legislature required resident health care providers to meet certain conditions. In return for meeting those conditions, the statute required that excess coverage would be available to the health care providers. Thus, the health care providers (and, indirectly, their employer corporation's insurer) are receiving the benefit of the relationship imposed by Kansas statute.

It is

ORDERED that judgment shall be entered in favor of the plaintiff and against the defendant, such that the rights of the parties are declared to be in accordance with the findings of fact and conclusions of law contained in this order and, more specifically, the plaintiff is liable for only the first $200,000 of aggregate liability in the settlement of *Allen v. Morantz, et al.*, Case No. CV83-13845, and the plaintiff is entitled to full indemnification by the Kansas Health Care Stabilization Fund for amounts in excess of the first $200,000 of aggregate liability in settlement of the Allen case. In addition to the fund's reimbursement to the plaintiff, costs shall be borne by the defendant.

/s/ Dean Whipple
DEAN WHIPPLE
UNITED STATES
DISTRICT JUDGE

DATED: May 10, 1989
Kansas City, Missouri

UNITED STATES COURT OF APPEALS

FOR THE EIGHTH CIRCUIT

No. 89-1976WM	*	
	*	
The Medical Protective Company,	*	Order Denying Petition for Rehearing and Suggestion for Rehearing En Banc
Appellee,	*	
	*	
v.	*	
	*	
Fletcher Bell,	*	
	*	
Appellant.	*	

Appellee's suggestion for rehearing en banc has been considered by the court and is denied by reason of the lack of a majority of the active judges voting to rehear the case en banc. Judge John R. Gibson did not participate in the vote.

Petition for rehearing by the panel is also denied.

October 3, 1990

Order Entered at the Direction of the Court:

/s/ Robert D. St. Vrain
Clerk, U.S. Court of Appeals, Eighth Circuit

OBSTETRICS & GYNECOLOGY LIMITED OF KANSAS CITY, INC., a Missouri Professional Corporation, Formerly Known as Knock, Buckner, Youngblood, Bickley & Zeller, Inc., a Missouri Professional Corporation, Appellee,

and

St. Paul Fire and Marine Company, a Minnesota Corporation, Appellee/Cross-Appellant,

v.

Robert C. BUCKNER, M.D., Defendant,

and

Fletcher Bell, Commissioner of Insurance for the State of Kansas, Appellant/Cross-Appellee.

No. 63968.

Supreme Court of Kansas.

July 13, 1990.

Syllabus by the Court

In an action by the issuer of a medical malpractice insurance policy insuring both a physician who is a Kansas health care provider and a Missouri professional corporation not within the Health Care Provider Insurance Availability Act (K.S.A. 40-3401 *et seq.*) seeking indemnification from the Kansas Health Care Stabilization Fund for sums paid within the policy limits in settlement of a claim by a person allegedly injured through the professional negligence of the physician and filed against the professional corporation as the employer of the physician, the record is examined and it is *held:* (1) K.S.A. 40-3408 precludes the sought-for indemnification from

the Fund under the facts herein; and (2) the district court erred in entering judgment in favor of the insurer, all as is more fully set forth in the opinion.

Thomas V. Murray, of Barber, Emerson, Springer, Zinn & Murray, Lawrence, argued the cause and was on the brief, for appellant/cross-appellee Fletcher Bell.

Thomas D. Billam, of Wallace, Saunders, Austin, Brown, and Enochs, Chartered, Overland Park, argued the cause and was on the brief, for appellee/cross-appellant St. Paul Fire and Marine Co.

McFARLAND, Justice:

St. Paul Fire and Marine Company (St. Paul) paid $600,000 to settle a medical malpractice action in which two of its insureds, Dr. Robert Buckner and Obstetrics & Gynecology Limited of Kansas City, Inc. (Corporation) were named defendants. Through this action, St. Paul is seeking to recoup $500,000 of the settlement from the Kansas Health Care Stabilization Fund (Fund). The district court granted judgment in favor of St. Paul in the amount of $400,000. Fletcher Bell, Commissioner of Insurance and administrator of the Fund, appeals from the judgment. St. Paul cross-appeals from the district court's denial of prejudgment interest and the $100,000 reduction of its claim.

The underlying facts must be set forth in considerable detail. The Corporation is incorporated as a professional corporation under the laws of Missouri. It is not a "health care provider" as defined by K.S.A. 1989 Supp.

40-3401(f) as it is not "a professional corporation organized pursuant to the professional corporation law of Kansas." The parties agree the Corporation is not subject to the Health Care Provider Insurance Availability Act, K.S.A. 40-3401 *et seq.* (the Act).

St. Paul issued a Physicians and Surgeons Professional Policy. The basic coverage stated:

"Who's protected:

INDIVIDUAL

Knock, Kermit

Buckner, Robert C.

Bickley, James E.

Youngblood, James P.

ORGANIZATION

Drs. Knock, Buckner, Youngblood & Bickley, Inc."

Limits of coverage were $100,000 each person with a total limit of $300,000. The premium paid was $22,980.

The following endorsement, in pertinent part, was a part of the policy:

"KANSAS NON-RESIDENT PHYSICIAN ENDORSEMENT

. . . .

"Drs. Knock Buckner,

Youngblood & Bickley, Inc.

"*What this endorsement does*

"If you are a non-resident physician, this endorsement increases the limits of coverage for

your Physician Professional Liability Protection. But the increased Limits shown below apply only to the providing or withholding of *Limits of your coverage* Professional services outside the State of KANSAS.

"The additional premium of $5,848.00 increase[s] your coverage to:

$1,000,000	each person
1,000,000	total limit

"Who's protected

"This endorsement applies only to the following individuals or organizations:

James P. Youngblood

Drs. Knock, Buckner, Youngblood & Bickley, Inc.

"Other terms

"All other terms of your policy remain the same."

As noted in the case caption, the name of the professional corporation was changed to its present name after the issuance of the policy.

Appropriate notice of basic coverage was sent to Bell as to physicians Knock, Buckner, Bickley, and Schaeffer, who were health care providers within the definition of K.S.A. 1989 Supp. 40-3401(f), but not as to Youngblood or the Corporation, who were not subject to the Act. The business address of all physicians and the Corporation was listed as 1010 Carondelet Dr., Suite 328, Kansas City, Missouri 64114.

On December 11, 1977, Dr. Buckner delivered a baby, Christine Loetel, at St. Mary's Hospital in Kansas City,

Missouri. On July 6, 1982, a lawsuit was filed in Missouri on behalf of the child by her mother, Pamela J. Loetel, as mother and next friend, alleging that the delivery had been negligently performed and that Christine had been damaged as a result thereof. Dr. Buckner was a named defendant as was the Corporation on the basis of the doctrine of respondeat superior, Dr. Buckner being an employee of the Corporation.

St. Paul defended the action on behalf of its two insureds. Demand was made upon Bell by St. Paul for participation. A basic disagreement developed as to the respective obligation of the Fund and the policy of insurance. St. Paul contended the Fund had liability for any amount over $100,000. Bell contended St. Paul's liability extended to the first $1,100,000 of the claim. St. Paul ultimately settled the Loetel action for $600,000 on behalf of its two insureds. In its bookkeeping, St. Paul attributed $100,000 to Buckner's coverage and $500,000 to the Corporation's coverage. There is no contention the $600,000 settlement was unreasonable in amount.

St. Paul wanted to force the Fund to reimburse it for the $500,000 it believed it had been compelled to pay by Bell's wrongful refusal to participate. However, there was an impediment to the pursuit of the claim. There was no judgment against Buckner for $600,000. The settlement had been paid on behalf of Buckner *and* the Corporation, who were each insureds under the policy, and the settlement was within the total coverage afforded. St. Paul developed a strategy to overcome the impediment and achieve its goal. On November 18, 1986, an action was filed in the United States District Court for the District of Kansas (Civil Action No. 86-2516-0) wherein St. Paul and

the Corporation (in cooperation with St. Paul) sought the following:

Count I:

A judgment against Buckner for $500,000 based upon a theory of indemnity. More specifically, it was claimed that as the Corporation's liability was based upon the negligence of Buckner, its employee, through the doctrine of respondeat superior, indemnity by Buckner was appropriate; and

Count II:

A judgment against Bell in the amount of $500,000 on the basis the Fund was to pay any judgment or settlement against Buckner in any amount in excess of the basic coverage amount of $100,000.

St. Paul had previously entered into an agreement with Buckner and the Corporation whereby St. Paul: (1) would pay all attorney fees incurred by Buckner and the Corporation arising from this new action, and (2) would not execute against Buckner on any judgment rendered therein. Buckner filed a cross-claim against Bell for indemnification as to any judgment entered against him. St. Paul then had two avenues of recovery open. If St. Paul obtained a judgment against Buckner, then Buckner would be seeking payment of the amount from the Fund. Additionally, in Count II, it had the direct action against Bell based upon the Buckner judgment. For undisclosed reasons, by mutual agreement, the federal action was dismissed and an identical action, including the cross-claim, was filed in the District Court of Shawnee County. This is the action before us.

We turn now to what transpired in the district court. Volleys of summary judgment motions were fired: (1) by plaintiffs against Buckner on County I; (2) by plaintiffs against Bell on Count II; (3) by Bell against plaintiffs on Count II; (4) by Bell against Buckner on the latter's cross-claim; and (5) by Buckner against Bell on the cross-claim.

Highly summarized, the district court held that:

(1) resolution of the issues did not require that there be a judgment entered against Buckner individually herein;

(2) St. Paul could proceed directly against Bell to recoup monies which Bell had wrongfully compelled St. Paul to pay:

(3) Buckner and the Corporation each had $100,000 of applicable basic coverage;

(4) the endorsement to the policy had no applicability in the determination of the Fund's liability;

(5) the Fund was obligated to reimburse St. Paul in the amount of $400,000; and

(6) prejudgment interest was not authorized against the Fund.

The summary judgment motions were, accordingly, disposed of as follows: (1) Bell's motion as to Count II was denied; (2) plaintiff's motion as to Count II was granted in the reduced amount of $400,000 but denied as to the requested allowance of prejudgment interest; (3) the other three motions (Buckner's motions as to Count I and his cross-claim and Bell's motion as to the cross-claim) were denied as being moot.

The ultimate issue before us is easily stated. That is, does the Fund's coverage herein commence at the

$100,000 Buckner basic policy level as claimed by St. Paul, or at the $1,100,000 aggregate level of the policy as claimed by Bell? The difficulty lies in reducing the ultimate issue into subissues as St. Paul and Bell rely on different theories and statues as well as divergent public policy arguments. The confusion is increased by the fact that the district court added the Corporation's basic policy $100,000 coverage to that of Buckner's (thereby reducing the claimed recoupment to $400,000), which is inconsistent with anything argued by either party. Except for the clear-cut issue as to the failure of the district court to allow prejudgment interest, the rest of the case comes before us in a rather messy plait of overlapping and interlocking arguments with a goodly supply of stray hairs.

A logical starting point for our discussion is the Health Care Provider Insurance Availability Act (K.S.A. 40-3401 *et seq.*). In *State ex rel. Schneider v. Liggett*, 223 Lan. 610, 576 P.2d 221 (1978), we stated:

> "The Kansas Health Care Provider Insurance Availability Act was passed by the 1976 legislature as a partial response to increasing pressure brought upon Kansas health care providers because of the national medical malpractice crisis. The primary feature of the act is the requirement that all health care providers operating within the state must obtain professional malpractice liability insurance (40-3402) and pay a surcharge to the health care stabilization fund (40-3404). The law requires the provider to carry a basic policy of $100,000 per occurrence and an annual aggregate of $300,000 for all claims made during the period. The stabilization fund provides for the payment of claims in excess of policy limits. Included in the act is a provision

requiring every health care insurer to participate in an apportionment plan whereby any health care provider may obtain liability insurance from the plan if insurance from a conventional source (40-3413) is not available." 223 Kan. at 611, 576 P.2d 221.

K.S.A. 40-3408 provides:

"The insurer of a health care provider covered by the fund or self-insurer shall be liable only for the first $200,000 of a claim for personal injury or death arising out of the rendering of or the failure to render professional services by such health care provider, subject to an annual aggregate of $600,000 for all such claims against the health care provider. However, if any liability insurance in excess of such amounts is applicable to any claim or would be applicable in the absence of this act, any payments from the fund shall be excess over such amounts paid, payable or that would have been payable in the absence of this act. The liability of an insurer for claims made prior to July 1, 1984, shall not exceed those limits of insurance provided by such policy prior to July 1, 1984."

Note: The claim herein was made prior to July 1, 1984, and, hence, the earlier, lower limits of $100,000/$300,000 apply.

In *McGuire v. Sifers*, 235 Kan. 368, 681 P.2d 1025 (1984), we held that where a physician and the professional corporation are both health care providers under the Act, and each is required to maintain the specified insurance, the Fund's coverage is excess to the combined policy coverage of the two health care providers. The corporation's liability in *McGuire*, as in the case before us, was based upon respondeat superior.

It should, perhaps, be noted that in 1986 the legislature amended K.S.A. 40-3408 to add:

> "Notwithstanding anything herein to the contrary, as insurer that provides coverage to a health care provider may exclude from coverage any liability incurred by such provider from the rendering of or the failure to render professional services by any other health care provider who is required by K.S.A. 40-3402 and amendments thereto to maintain professional liability insurance in effect as a condition to rendering professional services as a health care provider in this state." L.1986, ch. 229, § 30.

This amendment made an effective alteration to *McGuire* but the amendment occurred after the time period involved herein.

The district court held that *McGuire* was not determinative as the Corporation herein is not a Kansas health care provider. It is true *McGuire* involved two health care providers under the Act and references is made to the Act's requirements. It is also true, however, that *McGuire* relies, in part, upon general corporation law for its resolution of the issue. Further, *McGuire* specifically refers to K.S.A. 40-3408 in the form applicable then (and to the claim herein) as follows:

" 'The insurer of a health care provider covered by the fund or self-insurer shall be liable only for the first one hundred thousand dollars ($100,000) of a claim for personal injury or death arising out of the rendering of or the failure to render professional services by such health care provider, subject to an annual aggregate of three hundred thousand dollars ($300,000) for all such claims against the health care provider. *However, if any liability*

insurance in excess of such amounts is applicable to any claim or would be applicable in the absence of this act, any payments from the fund shall be excess over such amounts paid, payable or that would have been payable in the absence of this act.' " 235 Kan. at 376, 681 P.2d 1025. (quoting K.S.A. 40-3408) (Emphasis supplied.).

Bell contends that the emphasized portion of K.S.A. 40-3408 is determinative herein. The argument has merit.

The lengthy and complex history of this litigation has cloaked it with considerable foliage. When the leaves are stripped away, the basic nature of the controversy becomes clear.

Five physicians are owners of the Corporation. The business of the Corporation relies basically on the practice of medicine by its employee-shareholder-physicians. The physicians are engaged in a medical speciality with high exposure to medical malpractice litigation – obstetrics and gynecology. All of the five physicians practice their profession in the State of Missouri. This is where their offices and professional corporation (incorporated under the law of Missouri) are located. Four of the five physicians reside in Kansas and are licensed to practice in Kansas and Missouri – hence, they come within the purview of the Act. The fifth physician (Youngblood) and the Corporation are not within the Act.

All five physicians have a genuine economic interest in maintaining adequate insurance to protect their personal assets, as well as those of their corporation, from litigation expense and the payment of malpractice judgments or settlements. An insurance policy was purchased from St. Paul which was obviously intended to provide

such coverage. Each of the five physicians and the Corporation acquired the basic $100,000/$300,000 coverage which was the amount required by the Act. The four physicians covered by the Act could rely on the Fund for excess coverage beyond the $100,000 claim limit. Youngblood and the Corporation had no Fund coverage and, therefore $900,000 of additional coverage was purchased for them through the endorsement.

The Loetel claim arose from the practice of medicine in Missouri and was, accordingly, filed in a Missouri court. Dr. Buckner and the Corporation were named codefendants, the latter on the basis of respondeat superior as the employer of Buckner. St. Paul defended both of its insureds as required by the policy. Had the Loetel case gone to trial and judgment, any of plaintiff's judgment would have been a joint judgment against the two insureds. There is no question but that St. Paul had a $1,100,000 exposure in the Loetel claim. It had a duty to act in good faith in settlement negotiations. When the opportunity to settle within the policy limit surfaced, Bell warned St. Paul that he believed there was a good possibility that a judgment could exceed the policy limits, thereby opening the door to a later claim of bad faith and possible exposure of St. Paul for payment of a judgment in excess of the policy limits. St. Paul and the district court designate this as coercion by Bell. Actually, the risk to St. Paul. was not dependent on the Fund's applicability. The risk would arise from bad faith shown by St. Paul to its insureds.

St. Paul settled the Loetel claim for $600,000. St. Paul acknowledges $100,000 was paid by it under Buckner's coverage and $500,000 on the Corporation's coverage.

Such payment was within the coverage limits of the respective insureds.

In this action, St. Paul is attempting to shift the $500,000 it paid under the Corporation's coverage to Buckner in an artificial claim that he should, as an employee of the Corporation, indemnify the Corporation for sums it (through its insurance carrier) had to pay as a result of the employee's negligence. That St. Paul had secured the cooperation of the Corporation and Buckner in this orchestrated action is amply demonstrated by the pre-litigation agreements wherein St. Paul promised to pay its insureds' cost of litigation and never to execute against Buckner personally for any judgment rendered against him. That such prior agreements were made is not surprising. The Corporation's coverage was purchased by the owners to protect their respective personal and corporate interests. They certainly would not contemplate that they could be held personally liable for indemnification on any sums paid to claimants under the corporate coverage. Indeed, it would be difficult to conceive of anything St. Paul could do that would have a greater chilling effect on its future sales of medical malpractice insurance than the type of litigation against Buckner before us if it were "for real." Clearly, the claim against Buckner is intended to serve only as a conduit to the Fund.

There is authority for the proposition that it is impermissible for an insurance carrier insuring both a physician and his professional corporation in a medical malpractice policy to pursue the negligent physician for indemnification for sums paid on behalf of the corporation. Illustrative thereof is *Continental Cas. Co. v. Empire Cas. Co.*, 713 P.2d 384 (Colo.App. 1985), *aff'd in part, rev'd*

in part on other grounds Empire Cas. Co. v. St. Paul Fire & Marine, 764 P.2d 1191 (Colo.1988), where it was held:

> "An insurer cannot subrogate against its own insured to assert the indemnification claim of its named insured. [Citation omitted.] This is so because, by definition, subrogation exists only with respect to rights of the insurer against third persons to whom the insurer owes no duty. [Citation omitted.] An insurance company has no subrogation rights against the negligence of its own insured. [Citation omitted.] To allow subrogation under such circumstances would permit an insurer, in effect, to pass the incidence of the loss, either partially or totally, from itself to its own insured, and thus avoid the coverage which its insured purchased. [Citation omitted.]" 713 P.2d at 394.

We need not decide this particular point, however, as no judgment was entered herein on St. Paul's claim against Buckner (Count I).

After careful consideration, we conclude that K.S.A. 40-3408 is controlling, specifically that portion which provides:

> "[I]f any liability insurance in excess of such amounts is applicable to any claim or would be applicable to any claim or would be applicable in the absence of this act, any payments from the fund shall be excess over such amounts paid, payable or that would have been payable in the absence of this act."

The policy before us was purchased to provide coverage for claims such as that made by Loetel and did, in fact, provide such coverage.

The 1986 amendment to K.S.A. 40-3408 which permits a carrier to exclude vicarious liability coverage of one health care provider from liability for the actions of another is inapplicable as: (1) the corporation is not a health care provider within the Act; (2) the policy does not contain the exclusion; and (3) the amendment occurred after the pertinent dates involved herein.

There is also a strong public policy argument in support of our resolution herein. The Corporation, unlike a professional corporation under the Act, did not pay the premium surcharge required by the Act to provide monies for the Fund. A contrary holding would give the Corporation a free ride on the Fund which is certainly not within the legislative intent of the Act. The claim herein arose through Buckner's practice of medicine in Missouri within his Missouri professional corporation. The fact that Buckner chose to reside in Kansas does not permit the issuer of the medical malpractice policy covering both Buckner and the Corporation for claims such as this to shift the Corporation's liability under Missouri law and the policy to the Fund. St. Paul paid $100,000 on behalf of Buckner and $500,000 on behalf of the Corporation who were codefendants in the Loetel action and were insureds under the policy. Such settlement was within the policy limits applicable to each of the insureds. We find no legal basis herein for shifting the payment made by St. Paul on behalf of the Missouri Corporation to the Fund.

We conclude the summary judgment entered against Bell must be reversed. This renders all other issues moot.

The judgment is reversed.

SIX, J., not participating.

Supreme Court, U.S.
FILED
JAN 28 1991
JOSEPH F. SPANIOL, JR.
CLERK

(2)

No. 90-1053

In The

Supreme Court of the United States

October Term, 1990

THE MEDICAL PROTECTIVE COMPANY,

Petitioner,

v.

RONALD TODD,

Respondent.

Petition For A Writ Of Certiorari To The United States Court Of Appeals For The Eighth Circuit

BRIEF IN OPPOSITION TO PETITION FOR A WRIT OF CERTIORARI

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LIST OF PARTIES

The Medical Protective Company and Fletcher Bell were the parties to the proceedings below. Fletcher Bell was originally named as defendant in his capacity as Commissioner of Insurance for the State of Kansas and administrator of the Kansas Health Care Stabilization Fund. On January 14, 1991, Ronald Todd succeeded Fletcher Bell as Commissioner of Insurance for the State of Kansas and as administrator of the Kansas Health Care Stabilization Fund. United States Supreme Court Rule 35.3 provides that when a public officer who is a party to the proceeding ceases to hold office, his successor in office is automatically substituted as a party. Ronald Todd therefore was automatically substituted as a party to this action on January 14, 1991.

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STATEMENT OF THE CASE

1. Factual Background

The Kansas Health Care Provider Insurance Availability Act, K.S.A. § 40-3401 *et seq.* (the "Kansas Act"), requires that every health care provider residing in, licensed in, or functioning in Kansas maintain a specified minimum amount of professional liability insurance. In this case, the operative minimum amount of professional liability insurance is $100,000. K.S.A. § 40-3402.[1] When a claim is brought against a covered health care provider for medical malpractice, the Kansas Act states that the insurer of the health care provider is liable only for the first $100,000 of a claim. K.S.A. § 40-3408. Resources of the Kansas Health Care Stabilization Fund (the "Kansas Fund"), created under the Kansas Act, K.S.A. § 40-3403, may then be expended to pay the remainder of a claim. However, the Kansas Act further provides that "if any liability insurance in excess of [the specified $100,000 minimum amount] is applicable to any claim or would be applicable in the absence of this act, any payment from the fund shall be excess over such amounts paid, payable or that would have been payable in the absence of this act." K.S.A. § 40-3408.

The Medical Protective Company ("Medical Protective") issued individual policies of professional liability insurance to Andrew B. Kaufman, M.D. and Robert Morantz, M.D., both of whom are health care providers under the terms of the Kansas Act. The liability limit of each

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[1] The current statutory minimum, although not applicable, is $200,000.

physician's policy was the minimum $100,000 per occurrence required under the Kansas Act. K.S.A. § 40-3402. In addition, Medical Protective issued a third policy of professional liability insurance to the physicians' employer, Arnold Schoolman, M.D., a Missouri corporation (the "Schoolman Corporation"). The liability limit of this third policy was $1,000,000 per occurrence.

In 1986, Medical Protective settled an underlying medical malpractice action against the physicians and the Schoolman Corporation for $715,000. Of this amount, $200,000 was paid by Medical Protective out of its respective coverages on Drs. Kaufman and Morantz. Medical Protective also paid $515,000 out of its coverage on the Schoolman Corporation. Prior to settling the case, Medical Protective demanded that the Kansas Fund assume responsibility for $515,000, the amount in excess of the physicians' liability limits. It has been Medical Protective's position that K.S.A. § 40-3403 obligates the Kansas Fund to pay a claim if it exceeds the liability limit of the insurance of individual health care providers. The Kansas Fund declined to pay on the grounds that all three policies issued by Medical Protective were applicable, and that pursuant to the Kansas Act any payment from the Kansas Fund would be excess over the combined liability limits of all three policies. K.S.A. § 40-3408. Medical Protective does not address the effect of K.S.A. § 40-3408 in its petition now before this Court.

Medical Protective asserts as fact that the liability of the "Schoolman Corporation" in the underlying medical malpractice action was vicarious. Contrary to Medical Protective's assertion, however, the allegations of negligence as to all defendants in the malpractice action were of direct and active negligence. Vicarious liability was

never pleaded. There was not even an allegation in the malpractice action that Drs. Kaufman and Morantz were employees of the Schoolman Corporation. In fact, the malpractice petition seems to allege a claim against the Schoolman Corporation for acts other than those of Drs. Kaufman and Morantz.

Significantly, the malpractice petition, which sought judgment against Dr. Kaufman, Dr. Morantz, and the Schoolman Corporation jointly and severally, remained on file without amendment for approximately three years. Even at the point of settlement immediately prior to trial, the petition was not amended. Thus, at no time in the malpractice action were there allegations even remotely suggesting that the Schoolman Corporation's liability was vicariously based on the acts of Drs. Kaufman and Morantz. Throughout this case, Medical Protective's claim that the Schoolman Corporation's liability was only vicarious has been vigorously disputed. Therefore, while the Kansas Act precludes recovery by Medical Protective as a matter of law even if vicarious liability is assumed, the existence of vicarious liability such that Medical Protective can properly claim a right of subrogation is a contested matter.

Medical Protective also erroneously characterizes the Kansas Fund simply as an excess insurance carrier. The Kansas Fund is not a private insurer, which might typically provide coverage to an insured and make payment pursuant to a contractual relationship with the insured. Instead, the Kansas Fund is a public entity. The Kansas Fund provides coverage and makes payments only when a statute duly enacted by the Kansas legislature authorizes it to do so. The issue herein is not, as Medical Protective contends, a coverage dispute between an

excess carrier for the physicians and an insurance carrier for the vicariously liable employer. The issue actually presented is whether the Kansas Act permits the Kansas Fund to contribute toward a malpractice settlement involving Kansas physicians when a non-resident professional corporation separately carries liability insurance that will cover the amount of the settlement, to the extent that the settlement exceeds the physicians' liability insurance limits. Simply put, this is a case requiring the interpretation and application of Kansas law by the federal courts.

2. Proceedings in the Lower Courts

Medical Protective filed a request for declaratory relief in the United States District Court for the Western District of Missouri against the Commissioner of Insurance for the State of Kansas, who also serves as administrator of the Kansas Fund.[2] Medical Protective sought reimbursement of $515,000 paid on behalf of the Schoolman Corporation in settlement of the underlying malpractice claim. In its order of May 10, 1989, the district court held that Medical Protective was entitled to reimbursement from the Kansas Fund. The district court reached this conclusion without aid of the Kansas Supreme Court's construction of section 40-3408 of the Kansas Act, as the state court had not yet made its ruling

[2] On January 14, 1991, Ronald Todd succeeded Fletcher Bell as Commissioner of Insurance for the State of Kansas and as administrator of the Kansas Fund. Pursuant to United States Supreme Court Rule 35.3, Mr. Todd is automatically substituted as the proper party in this action.

in *Obstetrics & Gynecology, Ltd. v. Buckner*, 247 Kan. 170, 795 P.2d 386 (1990). Despite the fact that the Kansas Fund was created and controlled by statute, the district court erroneously concluded that the Kansas Act was to be applied only after a "path of liability" had been determined. The district court further concluded in error that Missouri law applied to a determination of the Fund's coverage, even though the district court acknowledged that "the fund is created and operated by Kansas statute" and that "the fund's rights and duties arise from a Kansas statute, rather than from a traditional insurance contract." *The Medical Protective Company v. Bell*, 716 F. Supp. 392, 397 (W.D. Mo. 1989).

In its opinion filed August 21, 1990, the United States Court of Appeals for the Eighth Circuit reversed the judgment of the district court. The court of appeals rejected the district court's analysis, noting that the sole question was "whether the [Kansas Act] permitt[ed] the [Kansas] Fund to contribute toward a malpractice settlement against Kansas physicians whose nonresident professional corporation carries liability insurance covering the settlement." *The Medical Protective Company v. Bell*, 912 F.2d 244 (8th Cir. 1990). The Eighth Circuit held that the Kansas Act barred payment from the Kansas Fund if the professional corporation's liability insurance was adequate to satisfy a settlement that exceeded the required minimum coverage of the corporation's liable employees. *Id.* at 245. This ruling was made in reliance upon the decision in *Buckner*, wherein the Kansas Supreme Court reached a similar result by interpreting and applying the Kansas Act in a factual situation nearly identical to that in this case.

REASONS FOR DENYING THE PETITION

Medical Protective has presented a very narrow question for review by this Court. Although it makes vague references to the equal protection clause, the privileges and immunities clause, and the commerce clause, Medical Protective has not claimed that these constitutional provisions are directly applicable. Any such claim, if made, would be completely lacking in legal or factual foundation. No valid constitutional question is raised by the Kansas Act itself, or the Kansas Supreme Court's decision in *Buckner*. The only constitutional issue actually asserted by Medical Protective concerns a purported deprivation of an Article III right to federal diversity jurisdiction. In reality, the sole issue is whether a federal court sitting in diversity should give effect to the construction of a state statute by the highest court of that state, or whether the federal court should independently examine the state statute and substitute its judgment for that of the state court.

The essence of Medical Protective's argument is that the federal court in this case should have disregarded the decision of a state's highest court that has construed one of that state's statutes, and indulged in an independent examination and interpretation of the statute. Medical Protective's position is fundamentally inconsistent with this Court's sound and historic decision in *Erie Railroad Company v. Tompkins*, 304 U.S. 64, 58 S. Ct. 817, 82 L.Ed. 188 (1938). As the Court warned in *Erie*, for a federal court to exercise independent judgment regarding what a state law should be, would lead to undesirable practices in the selection of a forum and the inequitable administration of justice.

In *Buckner*, the Kansas Supreme Court held that section 40-3408 of the Kansas Act requires that all coverage applicable to a claim, including coverage issued to a vicariously liable professional corporation, must be exhausted prior to the Kansas Fund assuming responsibility for the claim. Therefore, *Buckner* is dispositive and precludes recovery by Medical Protective. The Eighth Circuit, which was required to apply the terms of the Kansas Act, properly did so in reliance upon and in keeping with the Kansas court's interpretation of the Kansas Act.

1. The Decision In *Erie Railroad Company v. Tompkins* Requires Denial Of The Petition.

Medical Protective argues that the Eighth Circuit should not have accepted the Kansas Supreme Court's ruling as to the meaning of the Kansas Act. Medical Protective's position directly contradicts the decision of this Court in *Erie Railroad Company v. Tompkins*, 304 U.S. 64, 58 S. Ct. 817, 82 L.Ed. 1188 (1938). In *Erie*, the Court held that a federal court sitting in diversity must apply the law of the state as declared by the state's highest court, and may not exercise independent judgment as to what the law of the state should be. The Court concluded that pre-*Erie* precedent had led to injustice, confusion, and efforts to abolish or limit diversity jurisdiction. 304 U.S. at 77. The Court observed that differing decisions in state and federal courts as to the same issue prevented uniformity in the law. *Id.* at 74. In addition, the Court found that the exercise of independent judgment by the federal courts as to matters of state law led to discrimination.

> Diversity of citizenship jurisdiction was conferred in order to prevent apprehended discrimination in state courts against those not citizens of the State. *Swift v. Tyson* introduced grave discrimination by non-citizens against citizens. It made rights enjoyed under the unwritten "general law" vary according to whether enforcement was sought in the state or in the federal court; and the privilege of selecting the court in which the right should be determined was conferred upon the non-citizen. Thus, the doctrine rendered impossible equal protection of the law.

Id. at 74-75. The Court also recognized that the federal courts ought not interfere with the independence of the states by declaring what the law of a state should be.

> [T]he Constitution of the United States . . . recognizes and preserves the autonomy and independence of the States – independence in the legislative and independence in their judicial departments. Supervision over either the legislative or the judicial action of the States is in no case permissible except as to matters by the Constitution specifically authorized or delegated to the United States. Any interference with either, except as thus permitted, is an invasion of the authority of the State and, to that extent, a denial of its independence.

Id. at 79.

In *Klaxon Company v. Stentor Electric Manufacturing Company*, 313 U.S. 487, 61 S. Ct. 1020, 85 L.Ed. 1477 (1941), the Court warned that independent determinations by federal courts of the "better view" of state law, without regard to the state's interpretation of its own law, "would constantly disturb equal administration of justice in coordinate state and federal courts sitting side by side." 313 U.S. at 496. Thus, the Court held that the proper function

of the federal court in a diversity case "is to ascertain what the state law is, not what it ought to be." *Id.* at 497. Similarly, in *Hanna v. Plumer*, 380 U.S. 460, 85 S. Ct. 1136, 14 L.Ed.2d 8 (1965), the Court found that "it would be unfair for the character or result of litigation materially to differ because the suit had been brought in a federal court," as opposed to state court. 380 U.S. at 467. The purpose of *Erie* was the "discouragement of forum shopping and avoidance of inequitable administration of the law." *Id.* at 468.

Medical Protective essentially makes the type of argument that has repeatedly been rejected under an *Erie* analysis. The very concerns expressed by the *Erie* Court caution that a federal court sitting in diversity should not disregard a state court's interpretation of that state's law. A federal court applying a state statute in a diversity case is in substance "only another court of the State." *Bernhardt v. Polygraphic Co.*, 350 U.S. 198, 76 S. Ct. 273, 100 L.Ed. 199 (1956). Allowing federal courts instead to exercise independent judgment with regard to what state law should be, would lead to nonuniformity in the law and forum shopping, and would involve an invasion of the state's independence. Thus, the Eighth Circuit's proper application of established Kansas law in this case was entirely proper, if not mandatory.

It also should be noted that Medical Protective has failed to cite any valid authority for the proposition that in a diversity case, a federal court should ignore a state court's interpretation of that state's law and independently determine what state law should be. Medical Protective presents its view of the general policy and

purpose underlying the creation of federal diversity jurisdiction, and suggests that in this case it was denied an impartial tribunal. The problem with Medical Protective's position is that regardless of whether the tribunal is state or federal, or located within or outside Kansas, Medical Protective is still subject to the same governing law, which is a Kansas statute and the Kansas Supreme Court's interpretation of that statute.

2. The Eighth Circuit Properly Relied Upon the Kansas Supreme Court's Construction of the Kansas Statute at Issue in This Case.

A state court has final authority to interpret that state's legislation. Federal courts not only accept, but are bound by, the construction given to a state's statutes by its courts. *Garner v. Louisiana*, 368 U.S. 157, 166, 82 S. Ct. 248, 7 L.Ed.2d 207 (1961); *Aero Mayflower Transit Company v. Board of Railroad Commissioners*, 332 U.S. 495, 499, 68 S. Ct. 167, 92 L.Ed. 99 (1947); *Lauf v. E. G. Schinner & Co.*, 303 U.S. 323, 328, 58 S. Ct. 578, 82 L.Ed. 872 (1938). Indeed, the construction of a state statute by the highest court of the state must be treated as if it had been incorporated into the words of the statute. *Poulos v. New Hampshire*, 345 U.S. 395, 402, 73 S. Ct. 760, 97 L.Ed. 1105 (1953).

The Eighth Circuit followed these principles in this case, stating that it was "bound by the construction given the statute by the highest court within the state." *The Medical Protective Company v. Bell*, 912 F.2d at 245. The Eighth Circuit rejected the analysis of the district court, and concluded that the Kansas Act was controlling as to the Kansas Fund's obligations. In determining that the

Kansas Fund was not required to reimburse Medical Protective for the amount in excess of the primary coverage issued to the two physicians, the Eighth Circuit adopted the construction of the Kansas Act as set forth by the Kansas Supreme Court in *Buckner*. Such action by the Eighth Circuit is entirely in keeping with this Court's admonition that a federal court sitting in diversity should give effect to a state's interpretation of its own law.[3]

Medical Protective's argument that it was deprived of the independent judgment of the federal judiciary through the Eighth Circuit's adoption of *Buckner* is meritless. In short, Medical Protective asks this Court to reject a portion of the *Erie* doctrine. If Medical Protective prevails, a federal court sitting in diversity would no longer be expected to follow the interpretation of a state statute as set forth by that state's highest court. Instead, the federal court could independently examine the statute, and substitute its judgment for that of the state court where the federal court deems the state court's interpretation to be incorrect. This is precisely the result *Erie* sought to avoid, and which the Eighth Circuit refused to sanction.

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[3] Significantly, the district court similarly observed that "[j]ust as the Kansas legislature cannot change a Missouri law, a court sitting in Missouri cannot change Kansas statutes. Rather, application of Kansas statutes includes application of the Kansas case law construing those statutes. . . . Further, federal courts look to the decisions of the highest court of the state as the final authority on state law." *The Medical Protective Company v. Bell*, 716 F. Supp. at 397. Presumably, even the district court would have found against Medical Protective had the Kansas Supreme Court's decision in *Buckner* been rendered prior to the district court's decision in this case.

3. The Kansas Supreme Court Properly Applied The Kansas Act In *Buckner*.

Medical Protective argues that *Buckner* is "untenable" because the Kansas Supreme Court failed to analyze the *Buckner* case in a manner similar to the analysis employed by the district court in this case. In so arguing, Medical Protective fails to address the actual analysis of the Kansas Act made by the Kansas court. Moreover, Medical Protective fails to mention section 40-3408 of the Kansas Act, upon which *Buckner* principally is based.

In the Kansas case, Dr. Buckner, a Kansas health care provider, and his employer, a Missouri corporation, were named as defendants in a medical malpractice action. St. Paul Fire and Marine Company ("St. Paul") insured both parties. An individual policy, with a liability limit of $100,000 per occurrence, insured Dr. Buckner. A separate policy with a liability limit of $1,000,000 per occurrence insured the professional corporation. St. Paul ultimately settled the underlying malpractice claim for $600,000. St. Paul then brought an action against Dr. Buckner seeking indemnification. In addition, St. Paul sought to recover directly against the administrator of the Kansas Fund for those amounts paid in excess of the coverage issued to Dr. Buckner.

The ultimate issue as noted by the Kansas Supreme Court was whether the Kansas Fund's coverage commenced after Dr. Buckner's policy limit had been exhausted, or only after the corporation's policy limit had also been exhausted. After reviewing the history of the Kansas Act and prior case law construing the Kansas Act, the Kansas Supreme Court held that the following portion of section 40-3408 was controlling:

> If any liability insurance in excess of such amounts [the $100,000 in coverage each health care provider is required to maintain under the Kansas Act] is applicable to any claim or would be applicable in the absence of this act, any payments from the fund shall be excess over such amounts paid, payable or that would have been payable in the absence of this act.

Buckner, 795 P.2d at 392. The Kansas court concluded that the professional corporation purchased the policy to provide coverage for claims based upon vicarious liability, and that such coverage was therefore applicable coverage. *Id.* As the claim was settled within the coverage issued to the physician and his professional corporation, the court found that the Kansas Fund had no obligation to contribute toward the settlement.

Buckner does not, as Medical Protective argues, reflect an unequal application of the Kansas statutory scheme against those entitled to its benefits. Consistent with section 40-3408 of the Kansas Act, health care providers continue to receive coverage for any claims made against them once all applicable coverage has been exhausted. Moreover, it is important to note that an out-of-state insured such as the Schoolman Corporation, has no right to the benefits of the Kansas Fund. As the court found in *Buckner*, the Kansas legislature surely did not intend for an insured who has not paid the premium surcharge required by the Kansas Act to obtain a "free ride on the Fund." Likewise, Medical Protective as insurer of the Schoolman Corporation is not entitled to profit at the expense of this public fund.

It was unnecessary for the court in *Buckner* to engage in a legal analysis similar to that of the district court in

this case. The Kansas Supreme Court recognized that the Kansas Fund was created and controlled by statute, and could provide coverage and make payment only when the governing statutes so provide. Specifically, the Kansas court properly gave effect to the plain meaning of section 40-3408 of the Kansas Act. There was no need to consider, much less comment upon, the district court's decision in this case, which was based upon a flawed analysis and which failed properly to implement Kansas law.

4. *Buckner* Is Consistent With Established Law.

Despite Medical Protective's contention, *Buckner* is not inconsistent with the prior decision of the Eighth Circuit in *Pacific National Insurance Co. v. Transport Insurance Co.*, 341 F.2d 514 (8th Cir.), *cert. denied*, 381 U.S. 912, 85 S. Ct. 1536, 14 L. Ed.2d 434 (1965). The facts of and legal analysis applied by the court in *Pacific National* are distinct from the facts of and legal analysis in *Buckner*. *Pacific National* involved a coverage dispute between two private insurance carriers. *Buckner* involved a public fund, and interpretation of the state statutory framework under which the fund must be operated. Section 40-3408 of the Kansas Act, which precludes any recovery by Medical Protective in this case, was not before the court in *Pacific National*.

Buckner in no way undermines the general principle that an employee's insurance must be exhausted before the insurer of a vicariously liable employer may be reached. In this case, the coverage provided to the physicians was exhausted prior to responsibility for the claim passing to the Schoolman Corporation. The additional

coverage provided by the Kansas Fund would apply pursuant to section 40-3408, only after all other applicable insurance coverage, *i.e.*, Medical Protective's coverage of the Schoolman Corporation, was exhausted.

The Eighth Circuit correctly recognized *Buckner* as controlling in this case. The Eighth Circuit understood that the Kansas Fund could make payment only in accordance with the terms of the Kansas Act. In adopting *Buckner,* the appeals court simply applied the Kansas Act as that state's highest court has interpreted and would apply the Act.

CONCLUSION

For the reasons stated herein, The Medical Protective Company's Petition for a Writ of Certiorari to the United States Court of Appeals for the Eighth Circuit should be denied.

Respectfully submitted,

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APPENDIX

KANSAS STATUTES ANNOTATED

Article 34. – HEALTH CARE PROVIDER INSURANCE

40-3401. Definitions. As used in this act the following terms shall have the meanings respectively ascribed to them herein:

(a) "Applicant" means any health care provider;

(b) "Basic coverage" means a policy of professional liability insurance required to be maintained by each health care provider pursuant to the provisions of subsection (a) or (b) of K.S.A. 40-3402;

(c) "Commissioner" means the commissioner of insurance;

(d) "Fiscal year" means the year commencing on the effective date of this act and each year, commencing on the first day of that month, thereafter;

(e) "Fund" means the health care stabilization fund established pursuant to subsection (a) of K.S.A. 40-3403;

(f) "Health care provider" means a person licensed to practice any branch of the healing arts by the state board of healing arts, a person who holds a temporary permit to practice any branch of the healing arts issued by the state board of healing arts, a person engaged in a postgraduate training program approved by the state board of healing arts, a medical care facility licensed by the department of health and environment, a health maintenance organization issued a certificate of authority by the commissioner of insurance, an optometrist

licensed by the board of examiners in optometry, a podiatrist registered by the state board of healing arts, a pharmacist registered by the state board of pharmacy, a licensed professional nurse who is licensed by the board of nursing and certified as a nurse anesthetist by the American association of nurse anesthetists, a professional corporation organized pursuant to the professional corporation law of Kansas by persons who are authorized by such law to form such a corporation and who are health care providers as defined by this subsection, a dentist certified by the state board of healing arts to administer anesthetics under K.S.A. 65-2899, a physical therapist registered by the state board of healing arts, or a mental health center or mental health clinic licensed by the secretary of social and rehabilitation services;

(g) "Inactive health care provider" means a person or other entity who purchased basic coverage or qualified as a self-insurer on or subsequent to the effective date of this act but who, at the time a claim is made for personal injury or death arising out of the rendering of or the failure to render professional services by such health care provider, does not have basic coverage or self-insurance in effect solely because such person is no longer engaged in rendering professional service as a health care provider;

(h) "Insurer" means any corporation, association, reciprocal exchange, inter-insurer and any other legal entity authorized to write bodily injury or property damage liability insurance in this state, including workmen's compensation and automobile liability insurance, pursuant to the provisions of article 9, 11, 12 or 16 of chapter 40 of Kansas Statutes Annotated;

(i) "Plan" means the operating and administrative rules and procedures developed by insurers and rating organizations or the commissioner to make professional liability insurance available to health care providers;

(j) "Professional liability insurance" means insurance providing coverage for legal liability arising out of the performance of professional services rendered or which should have been rendered by a health care provider;

(k) "Rating organization" means a corporation, an unincorporated association, a partnership or an individual licensed pursuant to K.S.A. 40-930 or K.S.A. 40-1114, or both sections, to make rates for professional liability insurance;

(l) "Self-insurer" means a health care provider who has qualified as a self-insurer pursuant to K.S.A. 40-3414, and amendments thereto;

(m) "Medical care facility" means the same when used in the health care provider insurance availability act as the meaning ascribed to that term in K.S.A. 65-425, except that as used in the health care provider insurance availability act such term, as it relates to insurance coverage under the health care provider insurance availability act, also includes any director, trustee, officer or administrator of a medical care facility;

(n) "Mental health center" means a mental health center licensed by the secretary of social and rehabilitation services under K.S.A. 1980 Supp. 75-3307b, except that as used in the health care provider insurance availability act such term, as it relates to insurance coverage

under the health care provider insurance availability act, also includes any director, trustee, officer or administrator of a mental health center;

(o) "Mental health clinic" means a mental health clinic licensed by the secretary of social and rehabilitation services under K.S.A. 1980 Supp. 75-3307b, except that as used in the health care provider insurance availability act such term, as it relates to insurance coverage under the health care provider insurance availability act, also includes any director, trustee, officer or administrator of a mental health clinic;

(p) "State institution for the mentally retarded" means Norton state hospital, Winfield state hospital and training center, Parsons state hospital and training center and the Kansas neurological institute.

40-3402. Professional liability insurance to be maintained by health care providers as condition to rendering services in state, exception, limits of coverage; information to be furnished by insurer; termination of coverage, notice; contents of policies issued in state; duties of certain insurance companies; surcharge and information required of nonresident health care providers and self-insurers. (a) A policy of professional liability insurance approved by the commissioner and issued by an insurer duly authorized to transact business in this state in which the limit of the insurer's liability is not less than one

hundred thousand dollars ($100,000) per occurrence, subject to not less than a three hundred thousand dollar ($300,000) annual aggregate for all claims made during the policy period, shall be maintained in effect by each resident health care provider as a condition to rendering professional service as a health care provider in this state, unless such health care provider is a self-insurer. Such policy shall provide as a minimum coverage for claims made during the term of the policy which were incurred during the term of such policy or during the prior term of a similar policy.

(1) Each insurer providing basic coverage shall within thirty (30) days after the premium for the basic coverage is received by the insurer or within thirty (30) days from the effective date of this act, whichever is later, notify the commissioner that such coverage is or will be in effect. Such notification shall be on a form approved by the commissioner and shall include information identifying the professional liability policy issued or to be issued, the name and address of all health care providers covered by the policy, the amount of the annual premium, the inception and expiration dates of the coverage and such other information as the commissioner shall require. A copy of the notice required by this subsection shall be furnished the named insured.

(2) In the event of termination of basic coverage by cancellation, nonrenewal, expiration or otherwise by either the insurer or named insured, notice of such termination shall be furnished by the insurer to the commissioner, the state agency which licenses, registers or certifies the named insured and the named insured. Such notice shall be provided no less than thirty (30) days

prior to the effective date of any termination initiated by the insurer or within ten (10) days after the date coverage is terminated at the request of the named insured and shall include the name and address of the health care provider or providers for whom basic coverage is terminated and the date basic coverage will cease to be in effect. No basic coverage shall be terminated by cancellation or failure to renew by the insurer unless such insurer provides a notice of termination as required by this subsection.

(3) Any professional liability insurance policy issued, delivered or in effect in this state on and after the effective date of this act shall contain or be endorsed to provide basic coverage as required by subsection (a) of this section. Notwithstanding any omitted or inconsistent language, any contract of professional liability insurance shall be construed to obligate the insurer to meet all the mandatory requirements and obligations of this act.

(b) Unless a nonresident health care provider is a self-insurer, such provider shall not render professional service as a health care provider in this state unless such provider maintains coverage in effect as prescribed by subsection (a) of this section, except such coverage may be provided by a non-admitted insurer who has filed the form required in paragraph (1) of subsection (b) of this section.

(1) Every insurance company authorized to transact business in this state, that is authorized to issue professional liability insurance in any jurisdiction, shall file with the commissioner, as a condition of its continued

transaction of business within this state, a form prescribed by the commissioner declaring that its professional liability insurance policies, wherever issued, shall be deemed to provide at least the insurance required by this subsection when the insured is rendering professional services as a nonresident health care provider in this state. Any non-admitted insurer may file such a form.

(2) every nonresident health care provider who is required to maintain basic coverage pursuant to this subsection shall pay the surcharge levied by the commissioner pursuant to subsection (a) of K.S.A. 40-3404 directly to the commissioner and shall furnish to the commissioner the information required in paragraph (1) of subsection (a) of this section.

(c) Every health care provider that is a self-insurer shall pay the surcharge levied by the commissioner pursuant to subsection (a) of K.S.A. 40-3404 directly to the commissioner and shall furnish to the commissioner the information required in paragraph (1) of subsection (a) of this section.

40-3403. Health care stabilization fund; establishment; administration; liability of fund; payments from fund; qualification of health care provider for coverage under fund. (a) For the purpose of paying damages for personal injury or death arising out of the rendering of or the failure to render professional services by a health care provider, self-insurer or inactive health care provider

subsequent to the time that such health care provider or self-insurer has qualified for coverage under the provisions of this act, there is hereby established the health care stabilization fund. The fund shall be held in trust in a segregated fund in the state treasury. The commissioner shall administer the fund or contract for the administration of the fund with an insurance company authorized to do business in this state.

(b) The fund shall be liable to pay: (1) Any amount due from a judgment or settlement which is in excess of the basic coverage liability of all liable resident health care providers or resident self-insurers for any such injury or death arising out of the rendering of or the failure to render professional services within or without this state; (2) any amount due from a judgment or settlement which is in excess of the basic coverage liability of all liable nonresident health care providers or nonresident self-insurers for any such injury or death arising out of the rendering or the failure to render professional services within this state. In no event shall the fund be obligated for claims against nonresident health care providers or nonresident self-insurers who have not complied with this act or for claims against nonresident health care providers or non-resident self-insurers that arose outside of this state; (3) any amount due from a judgment or settlement against a resident inactive health care provider for any such injury or death; (4) any amount due from a judgment or settlement against a nonresident inactive health care provider for any injury or death arising out of the rendering or failure to render professional services within this state. In no event shall the fund be obligated for claims against: (A) Nonresident

inactive health care providers who have not complied with this act; or (B) nonresident inactive health care providers for claims that arose outside of this state, unless such health care provider was a resident health care provider or resident self-insurer at the time such act occurred; (5) reasonable and necessary expenses for attorney's fees incurred in defending the fund against claims; (6) any amounts expended for reinsurance obtained to protect the best interests of the fund purchased by the committee on surety bonds and insurance pursuant to K.S.A. 1980 Supp. 75-4101; (7) reasonable and necessary actuarial expenses incurred in administering the act; and (8) annually to the plan or plans, any amount assessed or assessable from insurers under any plan or plans existing pursuant to K.S.A. 40-3413.

(c) All amounts for which the fund is liable pursuant to paragraphs (1), (2), (3) or (4) of subsection (b) of this section shall be paid promptly and in full if less than three hundred thousand dollars ($300,000) or if three hundred thousand dollars ($300,000) or more by installment payments of three hundred thousand dollars ($300,000) per fiscal year, the first installment to be paid within sixty (60) days after the fund becomes liable and each subsequent installment to be paid annually on the same date of the year the first installment was paid, until the claim has been paid in full. Any attorney's fees payable from such installment shall be similarly prorated.

(d) A health care provider shall be deemed to have qualified for coverage under the fund: (1) On and after the effective date of this act if basic coverage is then in effect; (2) subsequent to the effective date of this act, at such time as basic coverage becomes effective; or (3)

upon qualifying as a self-insurer pursuant to K.S.A. 40-3414.

40-3408. Liability of insurer or self-insurer for injury or death arising out of act or commission of health care provider, limitation; fund coverage excess over liability insurance coverage. The insurer of a health care provider covered by the fund or self-insurer shall be liable only for the first one hundred thousand dollars ($100,000) of a claim for personal injury or death arising out of the rendering of or the failure to render professional services by such health care provider, subject to an annual aggregate of three hundred thousand dollars ($300,000) for all such claims against the health care provider. However, if any liability insurance in excess of such amounts is applicable to any claim or would be applicable in the absence of this act, any payments from the fund shall be excess over such amounts paid, payable or that would have been payable in the absence of this act.

If any inactive health care provider has liability insurance in effect which is applicable to any claim or would be applicable in the absence of this act, any payments from the fund shall be excess over such amounts paid, payable or that would have been payable in the absence of this act.